Investigations Advisory Panel Report for the

Department of Mental Retardation

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REPORT FROM THE INVESTIGATIONS ADVISORY PANEL FOR THE DEPARTMENT OF MENTAL RETARDATION

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EXECUTIVE SUMMARY OF INVESTIGATIONS ADVISORY PANEL REPORT FOR THE DEPARTMENT OF MENTAL RETARDATION

This report has been prepared independently by the Investigations Advisory Panel for the Commissioner of the Massachusetts Department of Mental Retardation (DMR). It presents the panel's analysis of systemic, operational, management and other problems that have prevented the DMR Investigations Unit from efficiently and effectively addressing complaints of abuse and neglect of persons with mental retardation. In addition, the report offers a series of recommendations for restructuring and refocusing the DMR Investigations Unit, establishing minimum position requirements and training for investigators and expanding DMR's management information systems.

Most of the problems hampering the effectiveness of the Investigations Unit are systemic in nature, and include such issues as confusion over which state agency has jurisdiction for a particular complaint, excessive caseloads for DMR investigators, poor relations between DMR and the Disabled Persons Protection Commission (DPPC), the lack of a layered system prioritizing the most serious cases, and insufficient referral of criminal cases to the appropriate law enforcement agencies. There are also significant management problems facing the Unit, particularly in regard to the hiring, training and supervision of investigators. In addition, there has been a lack of consistent communication and support between supervisors and investigators. The "fire wall" between investigations and operations staff, the lack of a fully integrated management information system to track case status and outcomes, and the absence of technical support for complex matters such as interviewing in criminal cases and the determination of competency in DMR clients have further compromised the Unit's functioning. Finally, operational

problems have persisted in which there is little consistency in the manner by which complaints are investigated or resolved by DMR staff, poor adherence to time lines and the implementation of action plans, and a lack of integrity and clarity in the screening process for new cases.

The panel's recommendations presume that the DMR has established a risk assessment and protective services capacity to move swiftly, compassionately, and effectively to provide emergency protective services to persons with mental retardation who are in at-risk or established risk situations. Strong investigative capacity is squandered if the provisions of appropriate and needed services to restore a person to safety are not available.

The panel recommends both the establishment of new screening procedures and protocols for DPPC and DMR and the restructuring of DMR's Investigations Unit into two components, a Criminal Investigations Team and a Conflict Resolution Team. The proposed changes in the screening process will result in greater clarity regarding cases which will be investigated by the DPPC, those investigated by the DMR, and those that will be referred immediately to law enforcement agencies. DPPC would be responsible for, and only for, conducting investigations for individuals who are not served by DMR (so called "external" cases). DMR would bear responsibility for conducting investigations on all other non-mandated law enforcement or criminal referrals for complaints of abuse or neglect. If a complaint involves a serious criminal act, however, the case will be referred to the appropriate law enforcement agency for investigation. Neither the DPPC nor the DMR will conduct investigations independently into serious criminal matters.

The proposed Criminal Investigations Team of DMR would work collaboratively with appropriate law enforcement authorities in the conduct of a criminal investigation and during the prosecution of a case involving a person with mental retardation. The proposed Conflict

Resolution Team would conduct investigations into the wide range of non-criminal complaints which also require investigation and resolution to ensure the safety and well-being of DMR clients.

In addition, since the protection system is so complex and the types of complaints so varied, the report provides an illustration of how the new screening protocols and the proposed restructuring of the protection system would operate both within DMR and with its professional allies. Finally, the panel offers recommendations to improve the communication among the various constituencies regarding the conduct and outcome of investigations. We also note the importance of the commitment to change that must come not only from the DMR Investigations Unit, but also from the DMR administration, DPPC and the Massachusetts Legislature.

The panel recommends that:

- The DPPC refocus its role toward screening complaints according to a more precise and discerning protocol, referring cases to the appropriate agencies (for example DMR or law enforcement), and monitoring the quality of investigations conducted by DMR.
- The DPPC develop a new screening protocol to identify the specific information required for a complaint or referral.
- DPPC conduct all investigations involving persons with mental retardation who are not clients of the DMR.
- DPPC investigators meet the same training requirements as recommended for DMR investigators.
- A Criminal Investigations Team be created within the DMR Investigations Unit to work collaboratively with law enforcement and criminal justice authorities in a manner comparable to that now operating to investigate allegations of child sexual abuse.
- A Conflict Resolution Team be created to deal with the majority of allegations of non-criminal abuse and neglect received by DMR either directly or through referral from DPPC which are noncriminal or which for any reason cannot be criminally prosecuted.
- An Ombudsperson be appointed in each DMR region to resolve disputes arising from completed non-criminal investigations and to monitor the implementation of action plans.

In appropriate cases, unresolved complaints about investigations should be referred to the Governor's Commission on Mental Retardation.

- EOHHS and DPPC periodically conduct a joint review of investigations and make recommendations to the Governor and legislature.

- All investigators and supervisors in the DMR Investigations Unit and the DPPC be required to complete a 40 hour Basic Investigation training course.

- Criminal Investigations Team members and DPPC investigators be required to complete advanced training, including a 40 hour Rape Certification Course and a Forensic Interviewing Course. Conflict Resolution Team members be required to complete advanced training in mediation techniques.

- In-service training meetings with both investigators and supervisors be held in each region on a quarterly basis.

- Police departments and academies provide 8 hours of basic and/or in-service training regarding the provisions of M.G.L. c. 19C and other issues of concern to persons with mental retardation. A one-day conference for cross-discipline training by DMR, DPPC and law enforcement authorities is recommended.

- Minimum qualifications for staff positions in the Investigations Unit be established.

- DMR conduct training sessions for the staff of the Investigations Unit regarding the effective use of the Unit's management information system.

- DMR evaluate the new management information system to determine its effectiveness for the Investigations Unit.

- DMR commit sufficient staff resources to ensure the continued implementation and effectiveness of the management information system.

- The DMR assign an attorney to the Investigations Unit for consultation on criminal justice, competency, and other legal matters.

- The DMR provide appropriate professional consultation support staff to the Investigations Unit.

- DPPC prepare a plan for monitoring the activities of the DMR Investigations Unit and of DPPC investigations and provide a publicly available annual report on its monitoring activities and results.

- The DMR develop and make available a statement detailing the "Rights for Information" for cases under investigation.

INVESTIGATIONS ADVISORY PANEL REPORT FOR THE DEPARTMENT OF MENTAL RETARDATION

I. INTRODUCTION

In June 1997, Gerald Morrissey, Commissioner of the Massachusetts Department of Mental Retardation (DMR), appointed an Investigations Advisory Panel to determine how DMR "can improve its investigative capacity and systems for protecting the safety and well being of the people (they) serve." Toward that end, the panel was charged with examining DMR's intra-departmental and interagency relationships and specific problem areas of the DMR Investigations Unit, including: the hiring practices, training and supervision of investigative staff, the scope of investigations, the timeliness and quality of investigations and reports, internal and external communication procedures, and the provision and monitoring of protective services (*see Appendix A for Commissioner Morrissey's panel appointment letter*).

The panel was chaired by Northwestern District Attorney Elizabeth D. Scheibel, and was comprised of nine individuals representing the judiciary, the bar, law enforcement, academia and families. *(See Appendix B for a complete listing of panel members.)* As part of its task, the panel met 18 times between July 1997 and March 1998 to discuss pertinent issues. In addition public hearings were held in each of the five DMR regions and written statements were solicited widely (*see Appendix C for a list of panel meetings and public hearings).* Finally, individual interviews were conducted with senior staff of the DMR, the staff of the DMR Investigations Unit, including 28 investigators and 5 senior investigators, and with staff members of the Disabled Persons Protection Commission (DPPC).

The panel was formed in response to the findings of the report, *Are You Sure About This Guy?*, issued by the House of Representatives Post Audit and Oversight Bureau in June 1997. The report focused on several highly publicized cases involving the abuse of persons with mental retardation in Massachusetts, and on issues these cases highlighted in the management, operation, and outcomes of the DMR Investigations Unit.

This report represents the fifth review of some aspect of the DMR Investigations Unit since 1992, the year in which the current Investigations Unit was established. The others include: the aforementioned report from the House Post Audit and Oversight Bureau; a DPPC report on the sexual abuse of a Fernald State School resident; the 1992 DMR Task Force Report on the agency's Complaint and Investigation Procedures; and the 1992 Massachusetts Inspector General's report of the DMR Investigations Unit.

While in the majority of instances, the staff of the DMR Investigations Unit have performed well, these highly publicized cases have again brought attention to the systemic, management, and operational problems within DMR and have seriously eroded public confidence in the agency. The questions raised repeatedly during the past several years about the Unit's ability to direct thorough, timely, and effective investigations of troubling and, in some cases, criminal incidents underscore the importance of conducting a comprehensive review of the purpose and operation of the Investigations Unit and of developing an action plan to address its ongoing problems. This report offers our analysis and recommendations on this matter.

II. PROBLEMS FACED BY THE INVESTIGATIONS UNIT

A. Systemic problems

We have identified many systemic problems that have undercut the ability of the DMR to perform its protective missions. By "systemic" problems, we refer to issues which DMR does not have the legal authority to control and to issues emanating from gaps and overlaps with other agencies, such as the DPPC, the Executive Office of Health and Human Services (EOHHS), and the law enforcement and criminal justice system.

First, while the DMR is perceived as having global responsibility for the protection of persons with mental retardation from abuse and neglect, the legal reality is far different. In many respects, the agency's authority is constrained and confused by overlapping responsibilities with other agencies, particularly the DPPC, but also the Department of Social Services (DSS), the Department of Public Health (DPH), the Massachusetts Rehabilitation Commission (MRC), and the Executive Office of Elder Affairs (EOEA). These other agencies may exercise some jurisdiction or responsibility for the care and protection of persons with mental retardation, depending on the person's age (for DSS and EOEA), residential or day placement (for DPH and MRC), and other physical or mental conditions. In other circumstances, the DMR has no legal authority at all to investigate or sanction effectively complaints of abuse, as is vividly the case in complaints involving (1) victims who are not clients of the DMR (so called "external" cases), or (2) perpetrators who are not caregivers, or (3) programs which are not operated or licensed by, or under contract with, the DMR. This patchwork of responsibilities results inevitably in service gaps and duplication of effort.

Second, even with respect to complaints plainly within its range of responsibility, the DMR lacks the legal tools to conduct much more than permissive investigations. For example,

DMR investigators lack the power to summon witnesses, obtain search warrants or subpoena records.

Third, the lack of a coordinated infrastructure in support of the abuse investigations activities and training of all involved executive branch agencies, particularly in forensic and legal support, diminishes the capacity of DMR and other agencies to perform their similar protective missions.

Fourth, regarding complaints of criminal acts, the DMR is wholly dependent on action by independent law enforcement agencies, with whom it generally has no agreements, protocols, or standards for cooperative action.

Fifth, the relationship between the DMR and the DPPC, which is the DMR's primary source of complaints requiring investigation as well as the agency charged with monitoring DMR investigations, has been ineffectual and often conflictual. We expand on these systemic problems below.

The existing procedures for seeking the protection of persons with mental retardation are unclear, posing significant challenges for all parts of the system. Under current state law, there are multiple avenues by which complaints of abuse can be reported, but without clearly defined procedures and reporting mechanisms, the real possibility of some cases "slipping through the cracks" of the protection system has persisted. Consequently, there appears to be deep-seated concern among the general public about the degree to which persons with mental retardation are protected, and confusion among those involved in the relevant agencies regarding how these avenues should connect with each other, which agency has jurisdiction in a particular case, and where supervisory or monitoring responsibilities should reside.

The agencies involved in the protection of persons with Mental Retardation include DMR, DPPC, and the EOHHS. DPPC is an independent state agency designated to receive complaints of abuse as defined by M.G.L. c. 19C. *(See Appendix D for definitions.)* While it has the authority to investigate complaints with its own team of investigators, DPPC's normal practice is to refer cases screened in for investigations to the state agency with primary responsibility for the alleged victim (regardless of whether the person is a current recipient of services from the agency). In 1994, for example, of 1420 cases screened in by DPPC for investigation of alleged abuse against persons with mental retardation, 86% were referred to the DMR Investigations Unit for investigation. In addition, referrals for investigation of abuse can be made directly to DMR pursuant to agency regulations (115 CMR 9.0), as so-called "Section 9" cases. *(See Appendix E for definitions.)* These referrals may come from cases screened out by DPPC or from a direct report of an alleged incident or condition of mistreatment or illegal, inhumane or dangerous conduct toward a DMR client. According to 1997 data provided by DMR, over half (59.3%) of the 1514 investigations conducted were based on complaints covered by M.G.L. c. 19C. The required and permissible actions, operative time lines, and jurisdiction between M.G.L. c. 19C investigations and Section 9 investigations are sometimes overlapping and thus can cause confusion within the system. Finally, complaints about mistreatment of a person with mental retardation can also be lodged with EOHHS, which has a supervisory investigative unit that covers the agencies under its umbrella.

According to our review, there is a long history of uncooperative relations between DMR and DPPC, with particular problems regarding the quality and quantity of information provided to DMR on DPPC screened-in cases. DMR cannot impose requirements regarding necessary information, and does not have the authority to refuse cases referred by DPPC. As a result,

information on many of the cases transferred to DMR for investigation is incomplete, and some cases do not even meet the legal threshold for abuse established in M.G.L. c. 19C. Unfortunately, what should be a cooperative relationship among the parts of the state's system for the protection of persons with mental retardation is more commonly described as a relationship that has been fraught with friction, mistrust, and, at times, mutual disdain.

With little control over the volume or types of cases it receives from DPPC, the DMR Investigations Unit has had to expend valuable resources on every case, regardless of the differences in the type or severity of the complaints. For instance, one case may involve an allegation that a person with mental retardation had been raped while another may involve an "omission of care" allegation in which a person with mental retardation developed blisters on his or her foot caused by the wearing of new shoes. Moreover, the DMR Investigations Unit must accept cases involving persons with mental retardation who may not be known to DMR, who are not current service recipients (so-called "external" cases), or whose competency to make informed decisions may be questionable. Indeed, an inability to utilize existing structures to determine the competency of individuals with mental retardation involved in investigations remains an unresolved problem. Without the legal authority to intervene in the life of a presumably private citizen, DMR investigators have been faced with significant dilemmas when such cases are referred to DMR instead of being retained by DPPC. Related to this, the panel was particularly concerned by the apparent lack of clear standards (at least in practice) by which DPPC refers cases to DMR, especially given the significant differences in caseload volumes between DMR and DPPC investigators (the per investigator caseload of the DPPC is much smaller than that of the DMR).

Interestingly, neither DPPC nor DMR has a strong history of referring complaints to the appropriate law enforcement and criminal justice authorities. Despite the passage three years ago of an accommodations law for witnesses with mental retardation testifying in court (M.G.L. c. 233 s. 23E), there is still a general absence of formal procedures and cooperative agreements with law enforcement agencies for the management and investigation of complaints of criminal conduct. The panel encountered some cases in which DMR and DPPC have handled apparently criminal behavior (e.g., larceny, assault and battery, or sexual abuse) without involvement from the appropriate law enforcement authorities. In other cases, investigations by police and the Investigations Unit have proceeded in tandem, with little coordination or assessment of the risk that the Investigations Unit involvement and/or actions may undercut the prosecution of the case.

These are serious concerns. DPPC and DMR investigators are not required to be trained in conducting criminal investigations or in ensuring the rights of accused persons. Moreover, they do not have the authority to obtain summonses, search warrants or subpoenas. DMR and DPPC continue to conduct criminal investigations despite these considerable obstacles. This reflects a serious flaw in DMR's approach to criminal matters, as well as a major gap in its relations with the law enforcement and criminal justice system. We note parenthetically that some of the highly publicized cases that led to the creation of the panel were cases involving criminal issues.

B. Management problems

In studying the training and competency requirements for DMR investigators, the panel was alarmed to discover that there are no minimum requirements or mandates for continued in-service training. Further, the current position summary (job description) for a staff investigator

is inappropriate given their duties and training. There are no consistent management systems in place to ensure that specific investigators are qualified to investigate the cases assigned to them. The panel was particularly concerned that allegations of sexual assault could be handled by staff who were not trained to conduct sexual assault investigations. Moreover, there is no specialized training program for the Unit and no requirements for on-going training. Investigators are not notified nor are many aware of the many no-cost training opportunities available, and when training opportunities do arise for investigators, they are sometimes discouraged from attending because of their voluminous caseloads. Supervision also varies widely across the state, ranging from regular monitoring of cases by the senior investigator in one area to inconsistent review and discussion of cases in another. In short, investigators are expected to perform functions for which they may lack the necessary training and legal authority, and for which they may receive insufficient supervision.

The panel also reviewed the level of technical support available to investigators and learned that, until recently, they were subject to conflicting legal advice (if it was present at all), had virtually no professional support for criminal investigations, and had no regular opportunities to provide peer support and technical assistance across regional boundaries. In one region, this was even true within regional boundaries.

Finally, the panel examined the capacity of the Investigations Unit to detect patterns, such as repeat offenders, problematic agencies, etc., across its cases. The lack of a functional management information system that would help to reveal such patterns and ensure adherence to mandated time lines for investigations was notable. DMR's management information system has been under development since at least 1993, and it is still not fully on-line. Until recently, each DMR region maintained its own data, used its own formats, and established its own

categories of information. Clearly, these practices are unacceptable for the Investigations Unit because they compromise the efficiency and effectiveness needed for promoting a comprehensive, coordinated system for protecting persons with mental retardation. Although the management information systems developed recently within the Unit are considerably more sophisticated than earlier times, the significant length of time it has taken to achieve even a potentially functional management information system has contributed to the problems which prompted the current review.

C. Operational problems

Several operational problems undermine the ability of the DMR Investigations Unit to achieve the level of professionalism that is expected. First, there is no assurance of consistency in the way similar cases are investigated from region to region. The voluminous manuals available to investigators lack practical guidelines for both routine and extraordinary cases. Of particular concern is the absence of clearly defined protocols for the referral of apparent criminal cases to law enforcement agencies.

Second, reporting time lines are often not met. In some instances, this may occur because the required length of the reports may be disproportionate to the severity of the allegation. In others, it is a result of the sheer overload of work faced by investigators. Regardless of the reason, the chronicity of overdue reports sends poor messages to victims, to those being investigated, to those awaiting resolution of a complaint, and to those responsible for writing and implementing the subsequent action plan.

Third, the panel was also struck by the extent to which inadequate, non-responsive, and at times insensitive communication patterns exist between investigators and various parts of the

system--particularly families. The panel was informed frequently during the public hearings of allegations of "stonewalling", excessive use of "confidentiality" concerns to deny basic information, lack of cooperation and evasiveness, and inordinate delay in responding to requests for information on the status of cases. Regardless of the legitimacy of the withholding of information at various points in an investigation, the tolerance within the Investigations Unit for such frayed relationships with key constituencies is unacceptable.

Fourth, investigators have been left "out of the loop" within the agency, and have not been allowed to recommend any sanctions, services or changes as a result of their investigations. This policy sacrifices the critical knowledge that investigators have about a case that could (and some would argue, should) be beneficial in determining what actions might rectify the conditions which led to the investigation or reduce the likelihood of subsequent incidents. Moreover, although the action plans for a particular investigation are sent to the senior investigator, they are not shared routinely with the initial investigator. In theory, the goal of this policy is to maintain complete independence between investigators and operations, but its practical effect is to perpetuate a balkanized system that is full of confusion, friction, and disenchantment among those involved. Furthermore, the segregation of investigators has unwittingly encouraged an unhealthy secrecy about their work. The fact that the outcomes of investigations have not been integrated or coordinated systematically with the licensing and contracting procedures of DMR was particularly disturbing to the panel.

Fifth, many of the cases given to investigators raise questions about the integrity of the screening process, both at the DPPC and DMR levels. The panel encountered instances where the investigation may have been used inappropriately as a vehicle to access services which would otherwise not have been provided. We also uncovered many cases in which the complaints were

more illustrative of poor management and supervision of state or contracted employees than they were of abuse or neglect. Some of these cases represented interpersonal disputes (either between staff and clients or management and staff) which were characterized inappropriately as worthy of investigation. Indeed, some investigators described instances in which they felt they were called in to "do the dirty work" that should have been done by program managers. Aside from being a wasteful deployment of resources, this practice enables managers to shirk their responsibility to train, monitor, and oversee their staff. In addition, it highlights a need to develop new protocols for addressing instances of interpersonal conflict within the human services system. The existing investigatory interventions, which are based in an adversarial/prosecutorial methodology, seem inappropriate for most cases involving interpersonal disputes.

Finally, we discovered that the Investigations Unit is vulnerable to pressures -- subtle or otherwise -- that could compromise the integrity of investigation findings. For example, when additional agency funds are needed to rectify a situation which prompted an investigation (e.g., providing expanded services for an existing client or establishing coverage for a new one), there may be reluctance to press for the funding to meet those needs effectively. Related to this concern, there were instances cited in which information contained in reports was altered.

D. The Crisis in Public Confidence

It is obvious that complaints of abuse or neglect against employees of an agency can be a potential source of embarrassment or prompt defensiveness by any agency. Such complaints may call into question the agency's policies, procedures, and priorities. Indeed, many of those who spoke at the public hearings and those who submitted written statements to the panel took

the position that the Department simply could not investigate itself, and that an independent agency for investigations was needed. The panel considered these charges carefully and concluded differently.

First, there already *is* an independent state agency charged with investigating allegations of abuse and neglect of persons with mental retardation and for monitoring DMR's investigative activities. Ironically, however, DPPC is largely ignored by the public as an existing remedy. This may be a result of DPPC's practice of referring most cases involving persons with mental retardation to DMR. It may also be a result of the inconsistency with which DPPC decides which cases to retain for its own investigators and which to refer. To the general public, there is little understanding of the specific role that DPPC occupies within the system of protection for citizens with disabilities.

Second, some of the complaints that "DMR cannot investigate itself" come from individuals who were disappointed or disagreed with the findings of an investigation or the action or inaction taken following an investigation. For individuals who disagree with the findings of an investigation, a formal appeals process is available. For those who are disappointed with the action or inaction following an investigation, it is often more appropriate to direct their concerns to the operations units of DMR than to the Investigations Unit. Indeed, we heard of numerous instances in which the "action plans" were inexplicably delayed, inadequate to the problem, or poorly implemented. Curiously, investigators typically do not even see the "action plans" written as a result of their investigations. Although the "fire wall" limiting communication between the Investigations Unit and the operations units of DMR was designed to ensure the independence of investigations from undue influence of operations, it serves instead to exacerbate current problems, and ultimately exposes the need for *greater*

communication between investigators and DMR program administrators. Further, as noted earlier, communications between the Investigations Unit and those involved or affected by the conduct of an inquiry, particularly family members, have been a source of deep dissatisfaction, and may well have contributed to a public perception of poor performance within the Investigations Unit.

After careful consideration, the panel concluded that a strong internal investigative capacity is not only appropriate, but is also essential for an agency with responsibilities as profound and far-reaching as the DMR to meet its service and protective missions. This is not to ignore the danger of conflict of interest. But we prefer to treat that potential problem by deferring to law enforcement in cases involving potentially prosecutable criminal conduct, and in all other cases, by opening the investigative process up to new participants and more open procedures, rather than by involving external agents without knowledge of the system or client needs.

E. Special Issues for Investigations Involving DMR Clients

An ongoing problem faced by DMR investigators in conducting investigations of complaints of abuse involving a person with mental retardation concerns the difficulties of determining an individual client's competency. The issue of competency arises frequently, and the individual whose competency is questioned could be the victim, the complainant, a witness or an alleged perpetrator in an event under investigation. Unless adjudicated otherwise, persons with mental retardation age 18 and older are presumed to be competent to manage their affairs. However, extra care is obviously needed to make an accurate determination about legal competency as well as functional capacity to make prudent decisions on a case-by-case basis.

Even among persons presumed competent, there may be difficulty in communicative abilities and in the ability to appraise the appropriateness of different situations or actions. To assume that persons with mental retardation who are known or suspected to be in a potentially or blatantly risky, exploitative, or abusive situation are exercising their "rights" to be at risk is to abandon a basic rationale for public services. The panel felt very strongly that no one with mental retardation should be abused or neglected as a matter of "personal choice."

During this review, it appeared that there was an over reliance by DMR on the legal presumption of competency, which may have resulted in investigations not being pursued as fully as they perhaps should have been. In some instances, investigators have not been able to arrange for protective services or competency evaluations because they have been refused access to the victim by a guardian or other caregiver. When questions of competency arise, there has been little institutional support for investigators to obtain the necessary legal or clinical advice.

III. RECOMMENDATIONS

The panel's major recommendations regarding the DMR Investigations Unit center on the overall structure and purposes of the Investigations Unit, with additional suggestions about the Unit and its relationship with other aspects of DMR operations. This section provides a detailed articulation of those recommendations, as well as an overview of the framework in which the panel's recommendations were made. Certainly, no "perfect" protection system exists. Our approach, however, is designed to create a system based on greater team work both within DMR and among its professional allies and the larger community. There is no compelling rationale for an investigation and protection system that is based on isolation of investigators from logical and strategic allies.

A central responsibility of DMR is the long-term care, support and protection of people with mental retardation from abuse, neglect and victimization, by employees and contract providers of DMR, family members or other caregivers, and the general public. To achieve this, the DMR must be an active and respected partner within a complex, layered system that involves at least three administrative agencies, state-wide, regional and local law enforcement agencies, state-operated facilities, contract service providers, clients and families. This is not an easily achieved goal, but we believe that criteria exist for the optimal management and operation of an appropriate, coordinated system. Meeting those criteria will require fundamental changes in the manner by which the Investigations Unit and the larger protection system operate.

The proposed restructuring requires the establishment of a risk screening and protective services capacity within the DMR to respond appropriately, swiftly, and effectively to provide emergency services to persons with mental retardation who are at risk for emotional, sexual, or

physical abuse. We are aware of the current efforts within DMR to develop a risk screening protocol to both identify problems before they escalate and also to respond in an responsible manner. We make no specific recommendations on the organization of a risk assessment and protective services capacity, but it is critical to acknowledge the central importance of such a capacity to the state's ability to meet its obligations to persons with mental retardation. Clearly, the work of the Investigations Unit needs to be linked to the operations of a risk assessment and protective services capacity. In this important instance, the "fire wall" between investigations and operational components of the DMR that has existed in the past needs to be eliminated.

A. Recommendations for the Role of the DPPC

The principal entry point for complaints of abuse or neglect of persons with mental retardation is the DPPC, which is legally responsible for screening all complaints and monitoring investigations by other agencies within its jurisdiction. We believe that the DPPC should retain these central and vital responsibilities. As noted earlier, the DPPC has the discretion to conduct investigations on its own or to assign cases to DMR, the Massachusetts Rehabilitation Commission (MRC) or the Department of Mental Health (DMH) for investigation. Like the DMR Investigations Unit, however, the DPPC has no enforcement authority, no subpoena or other police investigation powers, and no capacity to provide emergency protective services. *Therefore, we recommend that DPPC refocus its role toward screening complaints according to a more precise and discerning protocol, referring cases to the appropriate agencies (for example DMR or law enforcement, as appropriate), and monitoring the quality of investigations conducted by DMR.* A critical component of the proposed restructured system is the need for validity of the screening procedures which form

its foundation. *Therefore, we recommend that the DPPC develop a new screening protocol to identify the specific information required for a complaint or referral.* A more specific protocol will serve to reduce the number of "frivolous" cases and cases in which most reasonable persons would agree that not enough evidence is available to proceed. In addition, a new protocol would encourage more careful screening of cases by DPPC, which should translate into better management of the limited investigation resources and improved effectiveness and coordination between DMR and DPPC. The screening protocols developed by the Department of Social Services provide a model for this recommendation.

We further recommend that the DPPC retain all "external" cases for investigation by its own staff. We further recommend that investigators of the DPPC meet the same training requirements that we recommend for DMR investigators (explained below).

B. Recommendations for the Role of DMR Investigations

In the panel's view, the role of the DMR Investigations Unit has been misshapen by over involvement both in criminal cases beyond its competency and authority and also in non-criminal matters which would be better dealt with through other means (e.g., dispute resolution, mediation, resource allocation, licensing and contracting sanctions, or personnel training and sanctions). In many cases, the quasi-criminal techniques and the secretive, isolated operating style of the Investigations Unit have shifted inappropriately its focus away from the Department's goal of protecting persons with mental retardation and toward the identification and punishment of "wrong-doers."

Because DMR must respond to such a wide range of problems facing persons with mental retardation, it should develop different types of responses and interventions within the

Investigations Unit to address these different needs. There are multiple types of allegations of abuse and neglect that DMR investigators confront, including allegations that should be referred to the law enforcement and criminal justice system (either immediately by the DPPC or subsequently by the DMR based on findings resulting from investigation) which may or may not result in prosecution. Other allegations, while potentially serious, may not pass the legal threshold required for criminal investigation and prosecution. Finally, there are many allegations of abuse or omission of care which are non-criminal but nonetheless represent unacceptable behavior. The capacity to investigate non-criminal allegations, and allegations that do not pass the legal threshold for prosecution is a vital one for DMR (if involving clients of the DMR) and the DPPC (if involving a person with mental retardation who is not currently a client of DMR).

Allegations of abuse or neglect that should be investigated by law enforcement authorities should be referred to the criminal justice system. If the screening conducted by the DPPC reveals a basis for referral to the criminal justice system, it should do so immediately. If a case is referred to the DMR and subsequent investigation reveals a potentially criminal issue, the DMR should refer the case to law enforcement immediately. The ultimate objective of law enforcement is to protect citizens from becoming victims of crime and to prosecute offenders who commit crimes. Law enforcement and criminal justice agencies have been vastly underutilized in the current system of protection, and the panel sees no proper justification for limiting this role in any respect when a crime has been committed against or by a person with mental retardation. During this review, the panel determined the willingness of law enforcement authorities and prosecutors to become involved in finding solutions to the disability abuse problem (in a capacity similar to the way that they have become involved in the problems of

domestic violence or child abuse). There is no reason to supplant, duplicate or forego the benefits of the training, skills, authority and responsibility invested in local and state police departments, the District Attorneys, or the Attorney General.

We recognize, however, that the special circumstances of persons with mental retardation who are involved in the criminal justice system warrant special treatment.. The DMR Investigations Unit can provide valued, appropriate, and timely assistance to law enforcement agencies to ensure that persons with mental retardation are safeguarded and that coordination of efforts across the multiple agencies involved occurs. *Therefore, we recommend that a Criminal Investigation Team be created within the DMR Investigations Unit to work collaboratively with law enforcement and criminal justice authorities in a manner comparable to those now operating to investigate allegations of child sexual abuse.*

Although the need for greater coordination with law enforcement and criminal justice agencies is important, the number of allegations of abuse and neglect of a person with mental retardation that meet the legal threshold for referral to law enforcement agencies is much lower than the number of allegations of abuse and neglect that require a different level and type of intervention. The range of situations, events and circumstances which could trigger complaints for non-mandated referrals of abuse and neglect varies considerably, but it is still critical that clients, families and advocates be assured that there is a formal process to guarantee proper, timely consideration of and response to their concerns. A tiered system with different levels of priority and approaches to such cases -- from the utilization of dispute resolution and conflict management strategies to fact-finding investigations that presume wrong-doing and a need for disciplinary sanctions -- seems necessary within the agency. *Therefore, we recommend the creation of a Conflict Resolution Team to deal with the majority of allegations of abuse and*

neglect received by DMR either directly or through referral from DPPC which are noncriminal or which for any reason cannot be criminally prosecuted.

Although DMR has a legitimate duty to investigate allegations of sub-standard care, and current investigators seem truly dedicated to their mission and sense of independence, it is clear that the divided structure of the current system is particularly problematic for cases in which there is dissatisfaction about an investigation. Given the high stakes involved in any investigation, it is critical that a layered system of review be visible, independent and accessible to those affected by the investigatory system. *Therefore, we recommend the establishment of an Ombudsperson in each DMR region to resolve disputes arising from completed non-criminal investigations and to monitor the implementation of action plans. We further recommend that, in appropriate cases, unresolved complaints about investigations be referred to the Governor's Commission on Mental Retardation, which is authorized to intervene in systemic problems in the system of services.*

In addition, the role of EOHHS in the overall system of disability abuse protection has been ill-defined. As an umbrella agency, the panel views the role of EOHHS to be one of oversight, support and coordination of the state offices responsible for the protection of persons with mental retardation. *Therefore, we recommend that EOHHS and DPPC periodically conduct a joint review of investigations and make recommendations to the Governor and legislature.* EOHHS could also serve as a liaison on disability abuse issues with the Attorney General's Office, District Attorneys, the State Police and Police Academy, and the Massachusetts Chiefs of Police Association.

C. Training Requirements for DMR Investigators

In conducting a review of the training and skill requirements for DMR investigators, the panel was dismayed to discover that there are no minimum requirements or mandates for continued in-service training. Through interviews with investigators and a review of the materials given to them, it is clear that there has been no specific statewide training offered by DMR. However, despite the lack of formal training offered to investigators by DMR, the panel was impressed with the level of commitment demonstrated by investigators who had little or no agency-based resources or support but who sought out training opportunities and conferences (sometimes on their own time and at their own expense) in order to increase their skills.

The lack of basic and ongoing training by DMR is unacceptable for an agency dedicated to the protection of such a vulnerable population with highly specialized needs. Consistent, specific training for DMR investigators is essential to the maintenance of a high standard of services and investigations to and for its clients. *Therefore, we recommend that every investigator and supervisor complete a 40 hour Basic Investigation training course.* This training would be required to be completed within three months from the first day of employment and prior to undertaking investigations independently. The panel has developed a training model for investigators that should become standardized. The curriculum , based on courses available currently at the State Police Academy at no cost to the Department, should include, but not be limited to, the following subjects:

Victimization
Domestic Violence
Financial Crime
Evidence
Interview/Interrogation Techniques
Multidisciplinary Team Approaches to Investigation

Special Needs
Competency Issues
Basic Mediation Skills
Legal Updates
DMR Policy & Procedures
DPPC Policy & Procedures
Criteria for Referrals
Report Writing

The proposed standardized training would require an increase in resources currently allotted for training of all DMR investigators throughout the Commonwealth, but that financial burden can be lessened somewhat by involving DMR investigators in the training topics offered by the District Attorneys' Offices, DMR and community agencies, and other resource organizations such as the State Police Academy and the Massachusetts Office for Victim Assistance.

Beyond this basic training, both specialized training on the wide range of legal and clinical issues that are relevant to DMR clients and ongoing skills-building training are necessary for providing the level of expertise and understanding required for working effectively with the DMR client population. Investigators must continuously raise their levels of skill and knowledge in order to meet the challenges of their daily work. *Therefore, we recommend that DMR investigators on the proposed Criminal Investigations Team should be required to complete advanced training which would require the completion of the 40 hour Rape Certification Course taught at the State Police Academy and a Forensic Interviewing Course that results in certification. In addition, investigators from the proposed Conflict Resolution Team should be required to complete advanced training in mediation techniques.*

The review also highlighted the need for regular in-service training meetings in each region for supervisors and investigators. These trainings will help to familiarize all supervisors and investigators with the same basic investigation skills and techniques, and will work to

promote the sharing of expertise, the dissemination of new information, and the acquisition of new skills. They will also serve to promote consistency in methods for detecting abuse and conducting investigations across regions. *Therefore, we recommend that in-service training meetings with both investigators and supervisors be held in each region on a quarterly basis.*

In addition to training needed for DMR investigators, numerous outside organizations and agencies (e.g., state and local police and the District Attorneys' Offices) should be cross-trained on a myriad of issues specific to the DMR client population. These trainings will enhance the quality of investigations by educating law enforcement personnel about the special needs of persons with mental retardation, which will strengthen the quality of services provided to these victims of abuse and increase the likelihood of the successful prosecution of criminal acts. *Therefore, we recommend that police departments and academies include an additional 8 hours of basic training regarding the provisions of M.G.L. c. 19C and other issues of concern to persons with mental retardation. Further, we propose a one-day conference for cross-discipline training by DMR, DPPC and law enforcement authorities.*

We also suggest that any expansion of training also include the service providers to DMR clients, perhaps through a series of one-day trainings on subjects such as abuse identification, reporting protocols, the referral process, competency, and revisions in policies. These training sessions could be given by DMR and also should be made available to DPPC investigators, investigators from other EOHHS agencies, and staff from the Executive Office of Elder Affairs.

Under the proposed restructuring of the Investigations Unit, the panel envisions an investigative staff that has specific levels of expertise, experience and training. By standardizing the hiring requirements for staff, the Investigations Unit can alleviate the problems that have emerged when staff vacancies take too long to fill or when the varied backgrounds and

experience of employees promote a lack of consistency about how investigations should be conducted. *Therefore, we recommend the imposition of the following minimum qualifications for the hiring of various staff positions in the Investigations Unit.* For investigators of the proposed Criminal Investigations Team, the basic qualifications include a bachelor's degree in a relevant field, strong writing skills, and (within three months), completion of a 40 hour basic investigations course and certification in rape investigation and forensic interviewing. Investigators from the proposed Conflict Resolution Team would be subjected to the same requirements as criminal investigators except for the certifications requirements. Conflict Resolution Team investigators instead would need to complete a course in Advanced Mediation Training. For the senior investigators in each DMR region, the basic qualifications would include a bachelor's degree, experience or training in mediation and criminal investigations, and five years of professional experience in conducting investigations. A preferred qualification for the senior investigator position is a master's degree or five years of supervisory or management experience.

D. Management Information Systems

Although DMR has made some recent progress in the implementation of a reliable management information system for the Investigations Unit, the panel remains concerned by the agency's apparent reluctance to use computerized data bases to track its cases. Each of the five regions is now connected to the central office and can send and receive information regarding the status of investigations and the disposition of cases. In addition, each region now uses a standardized, ten-page Investigation Check List, which allows for the sorting and analysis of information by individual attributes or a combination of attributes contained in the form. For

instance, the new programs should enable DMR to identify the status and patterns of allegations and investigations for both DMR and DPPC cases. The new information system is also compatible with other DMR data bases, such as the systems for Licensing and Quality Assurance reviews. *Therefore, we recommend that DMR conduct an in-house training session for the staff of the Investigations Unit to ensure that employees are knowledgeable about how to complete and to enter the requisite information into the system, as well as the ways in which the data base can be used by investigators to improve the effectiveness of investigations.*

Although the new system has the capability of providing valuable information, it has not yet been tested sufficiently to determine its utility or whether corrections are needed. A pilot test was conducted in one region to determine how well the part of the system that tracks action plans was implemented. The initial results proved satisfactory for that region, and the ability to track action plans should be fully operational in all regions shortly. When each region is online, the data base should permit more efficient tracking of the number of action plans implemented, appealed or under consideration for any given period. Such data are critical in developing strategies to address disability abuse and mistreatment on a system-wide basis. Thus far, however, only one report on abuse has been generated using information obtained from the new data. *Therefore, we recommend additional testing of the new management information system in order to evaluate its effectiveness for the Investigations Unit.*

Clearly, a data base is only as good as the reliability of the information contained in it. The system will be maintained at each regional office, and staff should be assigned responsibility for entering case information into the data base. Depending on the number of investigations conducted in each region, this may require a significant, ongoing time commitment to keep the system files both accurate and current. *Given these considerations, we recommend that DMR*

commit sufficient staff resources to ensure the continued implementation and effectiveness of these systems.

IV. PROPOSED STRUCTURE AND FUNCTIONS OF THE DMR INVESTIGATIONS UNIT

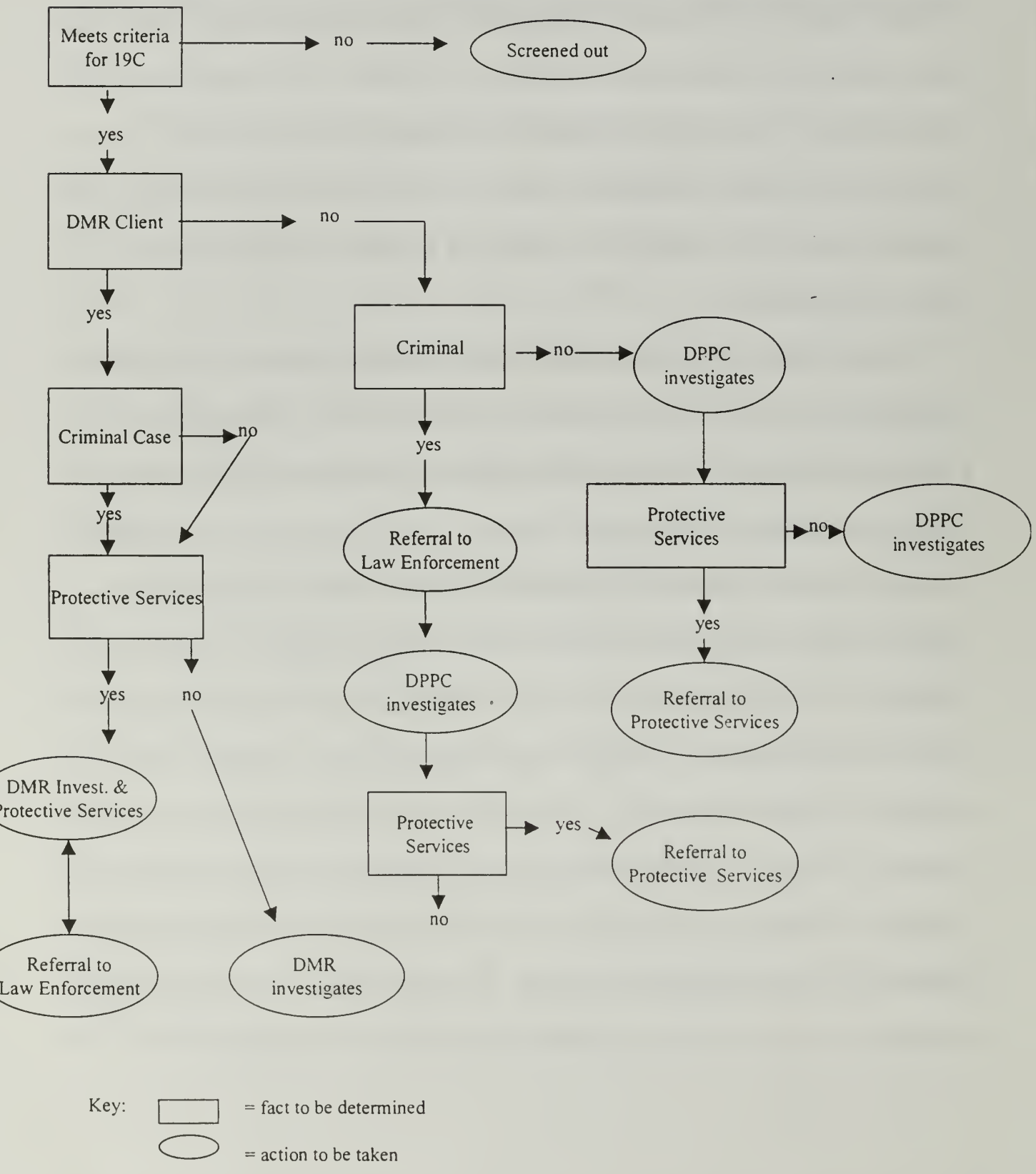
The panel recommends that the DMR Investigations Unit be restructured in significant ways, primarily through the adoption of new screening procedures and the creation of two "teams" -- the Criminal Investigations Team and the Conflict Resolution Team--which are designed to handle different needs and problems of persons with mental retardation. The recommended structure also presumes the establishment of a risk assessment and protective services capacity within DMR that is capable of providing emergency services to both DMR clients and to those who are found to be at risk but whose eligibility for services has yet to be established.

This segment of the report is intended to illustrate how the proposed restructuring of the Investigations Unit would operate within DMR, be linked to the revised screening protocols recommended for the DPPC, and be blended with the larger system of protection for persons with mental retardation. We note that the discussion that follows provides guidelines which will require more review and evaluation by the DMR in order to fine-tune the proposed system and make necessary changes to Departmental regulations and protocols. In some areas, we make specific recommendations for improvements in the system; in others, we identify the types of outcomes or results that are needed from the restructured system and acknowledge that the specific details to achieve them remain to be determined.

We note first that complaints can be lodged with the DPPC (under Section 19C) or with the DMR (under Section 9 of the DMR Regulations). If a complaint does not meet the criteria for a 19C investigation, but does meet the criteria for a Section 9 investigation, the intake of the complaint should occur within DMR Investigations and its screening procedures and actions should parallel those proposed below with reference to the DPPC. If the complaint meets the criteria for either a 19C or a Section 9 complaint, the intake should occur at the DPPC. If the complaint does not meet the criteria for either a 19C or a Section 9 investigation, the complainant should be so informed and encouraged to contact the Regional Director for discussion about the issue.

Figure 1 presents a basic scheme which would guide the disposition of complaints that are lodged with the DPPC (and which should be modeled by intakes conducted under Section 9 complaints within DMR). As indicated, there are four basic facts that need to be established to determine the routing of any specific complaint: (1) The complaint falls within DPPC jurisdiction (or for DMR intakes, the complaint falls within the criteria of Section 9); (2) The complaint involves criminal behavior; (3) The person with mental retardation involved in the complaint is a client of DMR; and (4) Current circumstances warrant referral for protective services. The disposition of any complaint would require resolution of each of these four facts. Referrals to law enforcement would include cases involving the unattended death of a person with mental retardation and cases in which a person with mental retardation is the victim of a criminal act, including rape or sexual assault, assault with bodily injury, sexual exploitation, financial exploitation, and other serious felonies. We note that Chapter 19C, Section 5 should be amended to be consistent with the Panel's recommendations (*see Appendix F*).

Figure 1
Schemata for Screening and Subsequent Activities



We provide a few examples to illustrate how the system is proposed to work. If the complaint falls within the DPPC jurisdiction, is non-criminal in nature, and involves a person who is not a client of the DMR, the case would be investigated by the DPPC. The determination of a need for protective services would then be made. If needed, such services would be provided by DMR protective services. The DPPC would retain investigative jurisdiction, however, because the person with mental retardation was not at the time of the complaint, a client of the DMR. If the person was a client of the DMR, and the other facts remained the same, the case would be referred to DMR for investigation. If the person was a client of the DMR and the allegation includes a serious criminal offense for which referral to law enforcement authorities is mandated, referral from the DPPC to the appropriate law enforcement agency and to the Criminal Investigation Team of the DMR Investigation Unit should be made by the DPPC. If the person was not a client of DMR and if the allegation fell within the offenses that mandate referral to the criminal justice system, the DPPC would refer the case to law enforcement and work collaboratively with the law enforcement agencies involved.

Given the complexity of legal issues that confront the operations of the DMR Investigations Unit, *we recommend that the DMR assign an attorney to the Unit for consultation on criminal justice, competency, and other legal issues. We also recommend that the DMR make available other professional support that may be needed in the investigatory process.*

A. Screening Protocols and Procedures for M.G.L. c. 19C Investigations

As mandated by law, DPPC would remain the initial screening agency, but its initial screening protocols would be broadened in scope and depth in order to enhance the protection

of persons with mental retardation and to form more cooperative relationships with the agencies to which it makes referrals of cases. In addition to the screening criteria established in M.G.L. c. 19C, the protocol would be expanded to include criteria related to the need for referral to law enforcement, determination of a referral as an "internal" (i.e., client of DMR) or "external" (i.e., client not served by DMR), and determination of the need for protective services from DMR.

The purpose of the initial screening is to determine, based on facts present in the report, whether there is or may be reasonable cause to believe that a person with mental retardation has been abused, mistreated or neglected, or is at risk of being abused, mistreated or neglected. When a case is "screened-in" -- that is, a complaint is accepted for action -- the complaint must include information that, on its face or through verification by collateral evidence, meets the criteria for a 19C investigation, the criteria for criminal referral, or both.

Under the proposed restructuring of the investigations system, the screening process would be a critical part of the overall process of reporting, identifying, assessing and providing services to persons with mental retardation. Beyond consultation with the person who made the initial complaint, the screening process could include examination of relevant files on the DMR client and making "collateral contacts" with individuals who may be able to provide information specific to the reported incident or the condition of the DMR client. These collateral contacts could include both professionals (e.g., the client's service coordinator) and non-professionals (e.g., the client's family or neighbors). We note that the DPPC has recently been assigned the services of up to five Massachusetts state troopers who will significantly augment the capacities of the DPPC to meet its screening responsibilities.

Procedures for External Cases

DPPC would assume direct responsibility for the investigation of all external cases. In such cases, complaints would be handled in different ways, depending on whether or not criminal criteria are met, and whether or not protective services are needed. Ideally, a screening decision would be made by DPPC as soon as possible but not more than 24 hours following receipt of the complaint. However, when complaints are received, the screener would make a determination about whether a case constitutes an emergency -- that is, a situation in which the failure to take immediate action would pose a threat of danger to the life, health, or physical safety of the person with mental retardation. If such a situation exists, DPPC would refer the person to DMR for protective services and notify the Regional Director.

If the criminal screening criteria are met, DPPC would notify the appropriate law enforcement agency in accordance with the newly established protocols and procedures for further criminal screening and emergency intervention by police authorities. In addition, the DPPC would assess the need for immediate protective services, and if warranted, notify DMR of the need. For all external cases, the DPPC would retain jurisdiction, and provide collaborative assistance to the law enforcement agencies who would assume lead responsibility for the investigation.

If protective services criteria, but not criminal criteria, are met in an external case. DPPC would refer it to DMR for protective services and notify the Regional Director.

Procedures for Internal Cases

DPPC's responsibilities in internal cases would be limited to screening and referral to DMR Investigations. If a criminal complaint is lodged, the referral would be made to the appropriate law enforcement agency and to the Criminal Investigations Team. If protective

services are indicated (and no criminal referral is necessary), appropriate services would be provided. If the complaint includes neither a criminal allegation nor the need for protective services, the DPPC would need to obtain sufficient information to ensure that the criteria for action are met. If necessary, collateral contacts with both professional and community personnel should be undertaken. Referral to the Conflict Mediation Team would then be made.

B. Monitoring Role of the DPPC

Other than conducting standardized screening, intake, and referral activities for internal cases, the only other role for DPPC is to monitor the quality of investigations conducted by the DMR. There is a variety of possible monitoring systems that could utilized, including random sampling of cases investigated by the Criminal Investigations Team and the Conflict Resolution Team, purposive sampling of cases to determine the quality of investigations of different types of allegations (e.g. criminal complaints that do not meet the threshold for prosecution, allegations of mismanagement of clients' financial resources, etc.), review of the effectiveness of the DMR management information system related to investigations, etc. We view effective, fair, and planned monitoring as a key activity in the system of protection for persons with mental retardation. *Therefore, we recommend that the DPPC prepare a plan for monitoring activities of the DMR Investigations Unit and the DPPC, and provide publicly available annual reports on its monitoring activities and results.*

C. DMR Criminal Investigations Team

The Criminal Investigations Team is designed to work in conjunction with law enforcement authorities during the investigation of a case involving a person with mental

retardation who is a client of the DMR. In order to accomplish this, DMR would cede jurisdiction to investigate criminal matters to the appropriate law enforcement agency. Qualified members of the DMR Criminal Investigations Team would work collaboratively with officials from relevant law enforcement agencies, with the benefit of clear and concise protocols and regulations governing potentially criminal cases. As described earlier, certain types of serious criminal allegations would be mandated to be referred (i.e., cases involving the unattended death of a person with mental retardation and cases in which the person with mental retardation is the victim of a criminal act, including rape or sexual assault, assault with bodily injury, sexual exploitation, financial exploitation, and other serious felonies). Non-mandated referrals involving criminal acts such as simple larceny, assault and battery with no injury, indecent exposure or malicious destruction of property would be investigated by members of the Criminal Investigations Team and then referred (if appropriate) to law enforcement or to the Conflict Resolution Team.

Investigators from the Criminal Investigations Team would assist law enforcement officers, prosecutors and other criminal justice officials by guiding interviews of persons with mental retardation, sharing information on the system of services in DMR, and obtaining files and records from prior investigations involving the same facility, victim, perpetrator or complainant. Within DMR, the Criminal Investigations Team would ensure that the rights and capacities of persons with mental retardation are protected during criminal investigations and prosecutions, and that any needed protective services are provided.

D. DMR Conflict Resolution Team

The Conflict Resolution Team is designed to address the large majority of allegations of abuse and neglect received directly by DMR or the DPPC which do not meet the criteria for referral to law enforcement agencies or the Criminal Investigations Team. The Conflict Resolution Team would also assume responsibility for cases involving crimes which will not or cannot be prosecuted. Initially, these cases would be assigned to the regional office, where a further assessment of the allegation would be made by the senior investigator. If the senior investigator determines that there is no need for protective services, then the case would be assigned to an investigator from the Conflict Resolution Team for investigation and subsequent mediation, counseling or dispute resolution.

For the most part, complaints directed to the Conflict Resolution Team would involve charges of sub-standard care or neglect, clients' problems with their medications, emotional injury or maltreatment, and interpersonal disputes between staff and clients. The primary goal of the Team will be to resolve differences of opinion, settle issues of fact, and mediate between conflicting parties' concerns about the delivery of services. The goal of the Conflict Resolution Team is to provide a respected vehicle for resolving problems at the earliest stage possible, thereby preventing potentially dangerous or conflicted situations from becoming escalated. The outcome of the process would be an action plan which could consist of any or all of the following components, among others: mediation, arbitration, additional client services, mandatory staff training or counseling, employee discipline, and agency sanctions against agency contracts or licenses.

The role of the investigator within the Conflict Resolution Team would be to determine the facts necessary to resolve the conflict. The investigator would serve as a member of the

Conflict Resolution Team assembled for the specific case. This team could also include the client's service coordinator, staff from the client's vendor agencies or other state employees who provide services, the Regional Ombudsperson, and, if additional expertise is needed, consultants to the DMR.

We recognize that the Conflict Resolution Team approach represents a radical departure from current practices. The panel feels strongly that DMR needs to design and implement this model in a way that is consistent with the spirit of the panel's recommendation and that is consistent with the best practices of the management of public agencies.

E. Communication

The panel was informed by DMR senior administrators that new strategies are being developed to create a Risk Management System. Such a system is vitally needed to aid direct care workers, supervisors, and administrators in preventing abusive, neglectful or sub-standard care, as well as to ensure swift action when questionable situations arise. Risk assessment and protective services are critical to the DMR's ability to intervene effectively and early when appropriately defined conditions arise. Personnel responsible for protective services would have primary responsibility for better communication within the DMR system with respect to clients whose care has been referred to Human Rights Committees, or who are being assisted by DMR attorneys for competency determinations and/or guardianship procedures, or who are involved in a matter under investigation by the DMR Investigations Unit.

The DMR must determine more explicit lines of communication among its various components with respect to the investigations process. The panel was particularly concerned about reports from family members about their frustration with and treatment by the existing

Investigations Unit. If reporting deadlines are missed, the public has a right to know why and when the report will be completed and available. If Human Rights Committees request information on the status of an investigation, a timely response should be expected. If a case is not screened in by either DMR (for a Section 9 allegation) or the DPPC (for a 19C allegation), the complainant has a right to know why this action was taken. In short, *we recommend that DMR develop and make available a statement detailing "Rights for Information."* In light of the emotional turmoil and stress typically associated with an investigation, and the various responsibilities invested in different components of the DMR system, more compassionate behaviors are necessary to avoid undue and unnecessary discomfort among those touched by the investigations process.

V. CONCLUSIONS

All persons with mental retardation and their families deserve a system that is timely, responsive and compassionate to their needs and concerns. Although this kind of institutional ethic should govern all DMR activities, it is especially important when an allegation of abuse, neglect or mistreatment of a DMR client has been made. In order to provide more effective, compassionate protection for persons with mental retardation from abuse and neglect, the DMR Investigations Unit needs to be restructured and refocused in fundamental ways.

Perhaps most importantly, DMR must move away from the secretive, segregated manner in which it has conducted investigations of abuse and neglect. This can be accomplished in part through the proposed restructuring of the Investigations Unit, but it will also require less dramatic, albeit significant, changes in DMR's organizational culture, including changing attitudes about the mission of the Unit, developing more open communication patterns and

professional support systems between DMR investigators and their supervisors, and improving relationships between senior administrators and DMR clients and their families.

Few (if any) of the problems articulated by families during the panel's public hearings seem insoluble to this panel. Although it is unrealistic to expect that the Investigations Unit (or any other protection agency) can prevent abuse or neglect in every circumstance, for all persons with mental retardation, it can address complaints of abuse or neglect with greater timeliness, sensitivity and common sense in order to protect DMR clients from immediate or future harm.

Nevertheless, despite the unique responsibilities that belong with the DMR Investigations Unit, it cannot accomplish its mission alone. Relations with DPPC must be improved and DPPC's own operational problems need to be addressed in order for the proposed restructuring to work. For this reason, EOHHS must play an important and visible role from the beginning to help resolve some of the longstanding issues between the DMR and the DPPC and to foster a more harmonious partnership between them. Without genuine cooperation and effective coordination between DMR and DPPC, the safety, health, and physical and emotional well-being of thousands of persons with mental retardation will remain at risk.

Finally, all of the panel's recommendations and suggestions are dependent upon a solid commitment from the legislature, EOHHS, DPPC, and DMR to provide sufficient funding and other forms of institutional support. This is the fifth major report on DMR investigations to be written in as many years. By adopting the proposed recommendations and fully committing the resources needed to implement them, the need for additional "crisis" reports will hopefully be obviated and public confidence will be restored.

Appendices

A. Original Appointment Letter to Panel Members from Commissioner Morrissey and Letter from Panel Requesting Time Extension for Review and Report (9/23/97)

B. List of Panel Members

C. List of Panel Meetings and Public Hearings

D. Governing Statute on Disability Abuse Protection (M.G.L. c. 19C)

E. DMR Regulations (115 CMR 9.00)

F. Recommended Mandated Referrals to DA's Offices at Point of Intake

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Mental Retardation
160 North Washington Street
Boston, MA 02114

William F. Weld
Governor

Argeo Paul Cellucci
Lieutenant Governor

Joseph Gallant
Secretary

Gerald J. Morrissey, Jr.
Commissioner

Area Code (617) 727-5608
TDD: (617) 727-9866

June 30, 1997

Elizabeth D. Scheibel, Northwestern District Attorney
One Court Square
Northampton, MA 01060

Betsy

Dear District Attorney Scheibel:

I am pleased to appoint you to the Investigations Advisory Panel for the Department of Mental Retardation. I want to thank you for agreeing to serve on this important panel. It will serve a vital role in determining how the DMR can improve its investigative capacity and systems for protecting the safety and well being of the people we serve.

I believe this panel has the talent to accomplish this goal. Your colleagues on this panel represent a diverse and distinguished group of individuals from outside of the DMR with the experience to review and evaluate thoroughly our investigations unit and interdepartmental and interagency relationships Thank you for agreeing to chair this panel. It will be composed of nine individuals representing the judiciary, law enforcement, academia, and families.

I am charging this panel with the following areas of inquiry:

- scope of investigations
- hiring practices and supervision of investigative staff
- staff training
- internal and external communications
- timeliness of investigations
- quality of reports
- the provision and monitoring of protective services.

This panel will also conduct a full review of DMR's procedures and practices, including those regarding notification and coordination with local police and district attorney's offices; determination of competency of victims; and communications and coordination with the Disabled Persons Protection Commission. The panel will be asked to complete its work and submit its findings to me within 120 days.

For background and review I am enclosing the following information;

- The 1992 Report of the Inspector General
- Investigation Regulations (115 CMR 9.00)
- The 1993 Report of the Commissioner's Task Force on Investigations Complaints and Procedures
- A copy of the 1997 Report on Investigation by the House of Representatives Post Audit and Oversight Bureau
- A list of the Investigation Advisory Panel members

The first meeting of the panel is scheduled for Monday, July 7, at the Glavin Regional Center, 214 Lake Street, in Shrewsbury, MA from 2 to 4 p.m. Directions are enclosed with this mailing. I look forward to meeting with you at this critical first meeting. I anticipate that the committee membership will determine subsequent meeting dates and times.

I am also pleased to announce that Margaret Chow-Menzer will coordinate staff to support the Investigations Advisory Panel. If you have any questions, please contact her at (617) 624-7703

I deeply appreciate your willingness to assist the Department in this inquiry and welcome you to the important work of this panel.

Sincerely,

Gerald J. Morrissey Jr.,
Commissioner

The Commonwealth of Massachusetts

DISTRICT ATTORNEY

NORTHWESTERN DISTRICT

ELIZABETH D. SCHEIBEL
DISTRICT ATTORNEY

September 23, 1997

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NORTHHAMPTON, MASSACHUSETTS 01060
(413) 586-8225
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Honorable James H. Fagan, Chairman
House Post Audit and Oversight Committee
State House, Room 146
Boston, Massachusetts 02133-1053

Dear Chairman Fagan:

On behalf of the members of the Investigations Advisory Panel for the Department of Mental Retardation (DMR), I want to update you and the members of your Committee on the status of the Panel's work to date.

On June 30, 1997, Investigations Advisory Panel members were appointed and charged with reviewing and evaluating the Department of Mental Retardation's Investigations Unit and its interdepartmental and interagency relationships. Specifically, the Panel was asked to review the scope of investigations, hiring, training and supervision of investigative staff, internal and external communications, timeliness of investigations, quality of reports and the provision and monitoring of protective services.

In addition, the Panel was asked to review DMR'S procedures and practices, including those regarding notification and coordination with local police and district attorney's offices, determination of competency of victims and communication and coordination with the Disabled Persons Protection Commission (DPPC). The Panel was asked to complete its work and submit its findings to Commissioner Gerald J. Morrissey, Jr. within 120 days.

On July 2, 1997, Commissioner Morrissey and I met to discuss the Investigations Advisory Panel and its mission. A meeting of the Panel was convened on July 7, 1997. At that meeting, an overview of the Department of Mental Retardation was given to the Panel members. This overview included historical and background information on DMR investigations, the role, responsibility, and relationship of other agencies also charged with investigating abuse and a review and discussion of the House Post Audit and Oversight Bureau's Report. The meeting also included a discussion of the Panel's function, including the organizational structure, support needs, goals, tasks and future meeting dates and times. It was agreed that, given the scope and complexity of its task, the Panel would meet every two weeks until the first week of November 1997 (approximately 120 days from the first meeting).

Since the first meeting, the Panel has continued to meet every two weeks. Panel members have received and reviewed hundreds of pages of documents relating to DMR

investigations. The Panel has interviewed the former Director, the former Deputy Director, two senior investigators and several staff investigators of the Department of Mental Retardation Investigations Unit. The Panel has also interviewed the Executive Director and General Counsel of the Disabled Persons Protection Commission.

The Panel has obtained statistics from each senior investigator in the five DMR regions regarding the numbers and types of investigations conducted from January 1996 through July 1997. The Panel is currently polling each district attorney's office to identify the total number of DMR referrals as well as the number of actual prosecutions that resulted from those referrals.

The Panel has held public hearings in DMR Regions 5 (Raynham) and 3 (Haverhill). Three additional public hearings have been scheduled in Region 1 (Holyoke) on September 24, 1997, Region 2 (Worcester) on September 29, 1997 and Region 6 (Boston) on October 21, 1997. The Panel is soliciting written comments regarding DMR'S Investigations Unit through October 21, 1997.

The Panel anticipates interviewing DPPC investigators and all DMR staff investigators. It also anticipates visiting a state facility and a community residence. The Panel will designate several subcommittees to focus on specific issues related to DMR'S Investigations Unit.

As it passes its halfway point, the Panel continues to move forward in a positive and significant manner. Because of the magnitude of its task, the Panel may request an extension of its term. Nevertheless, its members are confident that preliminary recommendations will be available in November 1997.

Very truly yours,

Elizabeth D. Scheibel

Elizabeth D. Scheibel
District Attorney
Northwestern District

EDS/ns

The DMR Investigations Advisory Panel Members

Elizabeth D. Scheibel is the District Attorney for the Northwestern District which encompasses Franklin and Hampshire County and the Town of Athol. She is the Chair for the DMR Investigations Advisory Panel.

Mary Beatty Muse is a retired Suffolk County Probate Court Judge. She now serves as a Master who conducts hearings on Rogers cases for the Department of Mental Retardation and the Department of Mental Health.

Marty Wyngaarden Krauss is the Chairperson of the Governor's Commission on Mental Retardation. She is an Associate Professor at the Heller School at Brandeis University and is also Director of the University's Starr Center for Mental Retardation.

Susan C. Harrington is a Massachusetts State Police Detective. For most of her 18 years, she has been an investigator in the Hampden, Hampshire and Franklin District Attorney's Offices, specializing in child sexual assault investigations.

Elizabeth A. Keegan is the Director of the Berkshire District Attorney's Victim Assistance Program. She has been in this field for over 15 years.

Donald N. Freedman is an attorney at the law firm of Rosenberg, Freedman and Goldstein. He is also a member of the Governor's Commission on Mental Retardation.

Richard W. Krant is a retired special agent of the FBI. He has a son who is a resident of the Wrentham Developmental Center.

Deborah A. McDonagh is the Director of Community Relations for the Suffolk County District Attorney's Office. She has a brother who is a resident of the Monson Developmental Center.

Richard M. Shaw is a Developmental Disabilities Specialist in the Boston Regional Office of the federal Health Care Financing Administration. He has served as a Quality Assurance Coordinator for a number of community based programs.

Commonwealth of Massachusetts
Department of Mental Retardation
Investigations Advisory Panel Meetings
July 1997 - March 1998

July 7, 1997

Panel Meeting: 2:00 P.M. - 4 P.M.
Glavin Regional Center
Shrewsbury

July 22, 1997

Panel Meeting: 2:00 P.M. - 4 P.M.
Glavin Regional Center
Shrewsbury

August 4, 1997

Panel Meeting: 2:00 P.M. - 4 P.M.
Glavin Regional Center
Shrewsbury

August 18, 1997

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

September 2, 1997

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

September 15, 1997 - Region V

Panel Meeting: 2:00 P.M. - 4:00 P.M.
Southeast Regional Office
68 North Main Street
Carver, MA
Second Floor Conference Room

Commonwealth of Massachusetts
Department of Mental Retardation
Investigations Advisory Panel Public Hearing Dates
July 1997 - March 1998

September 15, 1997 - Region V

Public Hearing: 5:00 P.M. - 7:00 P.M.
Merrill Elementary School
687 Pleasant Street
Raynham, MA

September 22, 1997 - Region III

Public Hearing: 5:00 P.M. - 7:00 P.M.
Northern Essex
Community College
Elliott Way
Haverhill, MA
Harold Bentley Library

September 24, 1997 - Region I

Public Hearing: 5:00 P.M. - 7:00 P.M.
Holyoke Community College
303 Homestead Ave.
Holyoke, MA
Forum - Building C

September 29, 1997 - Region II

Public Hearing: 5:00 P.M. - 7:00 P.M.
Worcester State College
Worcester, MA
Blue Lounge-Student Center

October 21, 1997 - Region VI

Public Hearing: 5:30 P.M. - 7:30 P.M
State Transportation Bldg.
10 Park Plaza, 2nd Floor
Boston, MA

September 29, 1997 - Region II

Panel Meeting: 2:00 P.M. - 4:00 P.M.
Worcester State College
486 Chandler Street
Worcester, MA
Fallon Room - Student Center

October 21, 1997 - Region VI

Panel Meeting: 2:00 P.M. - 4:00 P.M.
DMR - Central Office
3rd Floor Reception Area
160 North Washington Street
Boston, MA

November 3, 1997

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

November 14, 1997

Panel Meeting: 8:30 A.M. - 12:30 P.M.
Glavin Regional Center
Shrewsbury

November 24, 1997

Panel Meeting: 9:00 A.M. - 1:00 P.M.
Glavin Regional Center
Shrewsbury

December 10, 1997

Panel Meeting: 9:00 A.M. - 12 Noon
Middlesex West DMR Area Office
Westboro

December 22, 1997

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

January 5, 1998

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

January 21, 1998

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

February 2, 1998

Panel Meeting: 2:00 P.M. - 5:00 P.M.
Glavin Regional Center
Shrewsbury

March 11, 1998

Panel Meeting: 9:00 A.M. - Noon
Shrewsbury Public Library

March 23, 1998

Panel Meeting: 2:00 P.M. - 6:00 P.M.
Glavin Regional Center
Shrewsbury

CHAPTER 19C. DISABLED PERSONS PROTECTION COMMISSION

•Historical.Notes •References

HISTORICAL NOTES

GENERAL NOTES

1994 Main Volume

< The section headings for Massachusetts General Laws Annotated have been editorially supplied. >

< The provisions of Chapter 19C of the General Laws, consisting of §§ 1 to 12, were added as Chapter 19B by St.1986, c. 655, § 1, without reference to Chapter 19B as added by St.1986, c. 599, § 9. St.1987, c. 465, § 11, redesignated Chapter 19B, as added by St.1986, c. 655, § 1, as Chapter 19C. >

REFERENCES

LIBRARY REFERENCES

1997 ELECTRONIC UPDATE

Comments.

Social worker-client privilege, see M.P.S. vol. 19, Hughes, Evidentiary Standard 510.

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§ 1. Definitions

•Historical.Notes

As used in this chapter, the following words shall, unless the context requires otherwise, have the following meanings:--

"Abuse", an act or omission which results in serious physical or emotional injury to a disabled person; provided, however, that no person shall be considered to be abused for the sole reason that such person is being furnished or relies upon treatment in accordance with the tenets and teachings of a church or religious denomination by a duly accredited practitioner thereof.

"Caretaker", a disabled person's parent, guardian or other person or agency responsible for a disabled person's health or welfare, whether in the same home as the disabled person, a relative's home, a foster home or any other day or residential setting.

"Commission", the disabled persons protection commission established pursuant to section

two.

"Disabled person", a person between the ages of eighteen to fifty-nine, inclusive, who is mentally retarded, as defined by section one of chapter one hundred and twenty-three, [FN1] or who is otherwise mentally or physically disabled and as a result of such mental or physical disability is wholly or partially dependent on others to meet his daily living needs.

"General counsel" or "counsel", the general counsel of the executive office of human services.

"Mandated reporter", any physician, medical intern, hospital personnel engaged in the examination, care or treatment of persons, medical examiner, dentist, psychologist, nurse, chiropractor, podiatrist, osteopath, public or private school teacher, educational administrator, guidance or family counselor, day care worker, probation officer, social worker, foster parent, police officer or person employed by a state agency within the executive office of human services as defined by section sixteen of chapter six A, or employed by a private agency providing services to disabled persons who, in his professional capacity shall have reasonable cause to believe that a disabled person is suffering from a reportable condition.

"Recommendations", a statement or statements contained in an investigation report prepared pursuant to this chapter and based upon a conclusion that abuse has occurred which sets forth specific action or actions intended by the investigator to remedy said abuse, protect the particular disabled person or persons who are the subject or subjects of the report from further abuse and which responds to the specific protective needs of said disabled person or persons or group of disabled persons similarly situated.

"Reportable condition", a serious physical or emotional injury resulting from abuse, including unconsented to sexual activity.

"State agency", any agency of the commonwealth that provides services or treatment to disabled persons, including private agencies providing such services or treatment pursuant to a contract or agreement with an agency of the commonwealth.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

1997 ELECTRONIC UPDATE

Amended by St.1996, c. 259.

[FN1] Chapter 123, § 1, no longer defines "mentally retarded person".

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1996 Legislation

St.1996, c. 259, approved Aug. 7, 1996, inserted the definition of Recommendations.

1994 Main Volume

St.1986, c. 655, § 1, approved Dec. 24, 1986, added this chapter consisting of this section and §§ 2 to 12 as c. 19B, without reference to c. 19B, §§ 1 to 18, added by St.1986, c. 599, § 9. St.1987, c. 465, § 11, redesignated the provisions of this chapter as c. 19C, § 1 et seq.

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 1.

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§ 2. Establishment of disabled persons protection commission; membership; terms; compensation; annual report

•Historical.Notes

There is hereby established a commission for the protection of disabled persons, to be known as the disabled persons protection commission. The purpose of the commission shall be to provide for the investigation and remediation of instances of abuse of disabled persons in the commonwealth. The commission shall consist of three members to be appointed by the governor, one of whom he shall designate as chairman. Members of the commission shall serve for terms of no more than five years. No person shall be appointed to more than one full five-year term on the commission. The term of any commissioner shall not be coterminous with that of another. Members of the commission may be removed by the governor for gross misconduct, substantial neglect of duty, inability to discharge the powers and duties of office, or conviction of a felony. Any vacancy occurring on the commission shall be filled within ninety days by the original appointing authority. A person appointed to fill a vacancy occurring other than by expiration of a term of office shall be appointed for the unexpired term of the member he succeeds, and shall be eligible for appointment to one full five-year term. Any member whose term has expired shall continue to serve until such member's successor has been duly appointed and qualified. Members of the commission shall be compensated for work performed for the commission at such rate as the secretary of administration and finance shall determine and shall be reimbursed for their expenses. The commission shall annually report to the general court and the governor concerning the action it has taken; the names and salaries and duties of all individuals in its employ and the money it has disbursed; and shall make such further reports on matters within its jurisdiction as may appear necessary. Subject to the provisions of clause (a) of section three, the commission shall employ an executive director and a general counsel. The executive director shall be responsible for the administrative operation of the commission and shall perform such other tasks as the commission shall determine. The general counsel shall be the chief legal officer of the commission.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11. Amended by St.1991, c. 138, § 103.

1997 ELECTRONIC UPDATE

Amended by St.1996, c. 151, § 82.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1996 Legislation

St.1996, c. 151, § 82, approved June 30, 1996, and by § 690 made effective July 1, 1996, rewrote the section, which prior thereto read:

"There is hereby established, a commission for the protection of disabled persons, to be known as the disabled persons protection commission. The purpose of the commission shall be to provide for the investigation and remediation of instances of abuse of disabled persons in the commonwealth. The commission shall consist of three members to be appointed by the governor, one of whom he shall designate as chairman. Members of the commission shall serve for terms of three years. Any member whose term has expired shall continue to serve until such member's successor has been duly appointed and qualified. Any member shall be eligible for reappointment. Members may be removed by the governor for willful misconduct or neglect of duty or for inability to perform the powers and duties of the office. Members of the commission shall be compensated for work performed for the commission at such rate as the commissioner of administration shall determine and shall be reimbursed for their expenses."

1994 Main Volume

St.1986, c. 655, § 2, approved Dec. 24, 1986, provides:

"Notwithstanding the provisions of any general or special law to the contrary, the initial appointment of members of the disabled persons protection commission, pursuant to section two of chapter nineteen C of the General Laws, inserted by section one of this act, shall be one for a term ending January first, nineteen hundred and eighty-eight, one for a term ending January first, nineteen hundred and eighty-nine and the term of the chairman of said commission ending January first, nineteen hundred and ninety." [Amended by St.1987, c. 465, § 69.]

St.1987, c. 465, § 69, an emergency act, was approved Nov. 3, 1987.

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 2.

St.1991, c. 138, § 103, approved July 10, 1991, and by § 393 made effective as of July 1, 1991, in the first sentence, deleted "within, but not subject to the control of, the executive office of human services" following "established".

The Governor's purported disapproval of St.1991, c. 138, § 103 was held invalid. See Opinion of the Justices (1991) 582 N.E.2d 504, 411 Mass. 1201.

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§ 3. Powers and duties

•Historical.Notes •References

The commission shall have the following powers and duties:--

(a) to employ, subject to appropriation, such staff as shall be necessary to carry out its duties pursuant to this chapter; provided, however, that the commission shall establish written standards for the position of investigator and shall hire investigators whose education and training qualifies them for the position pursuant to the standards established by said commission; and provided further, that the commission shall take such steps as are necessary to ensure that the conduct of each investigator meets or exceeds such standards. For the purposes of determining the standards established under this section, the commission shall confer with the district attorneys and the attorney general. Such staff shall serve at the pleasure of the commission and shall not be subject to the provisions of chapter thirty-one;

(b) to promulgate, pursuant to the provisions of chapter thirty A, rules and regulations to carry out the purposes of this chapter, including rules governing the conduct of hearings conducted pursuant to section eight;

(c) to provide for the investigation of alleged abuse of disabled persons initiated pursuant to section four;

(d) to designate other state agencies within the executive office of human services for the furnishing of protective services in accordance with the provisions of section six;

(e) to issue reports, including findings of facts and recommendations, upon concluding an investigation, and to refer matters upon which investigations have been completed pursuant to section nine;

(f) to take appropriate measures to notify state agencies, disabled persons and other interested parties of the provisions of this chapter;

(g) to maintain files, records of investigations and reports which shall be retained and made available in accordance with the provisions of chapters sixty-six and sixty-six A;

(h) to develop standards for deferral of investigations to the executive office of human services and to agencies within the executive office of human services under section twelve and in consultation with the secretary of the executive office of human services.

(i) to establish within the commission a special investigative unit, which shall have sole responsibility for the initial investigation of all reports of abuse received by the commission in connection with which there is an allegation of criminal conduct. The colonel of the state police shall assign not fewer than five state police officers to the special investigative unit.

The commission shall promulgate rules and regulations establishing procedures to exclude personally identifiable information regarding the subjects of investigations and to carry out the responsibilities of this chapter in such a way as to disclose as little personally identifiable information as possible.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

1997 ELECTRONIC UPDATE

Amended by St.1997, c. 43, §§ 16, 17.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1997 Legislation

St.1997, c. 43, § 16, an emergency act, approved July 10, 1997, and by § 311 made effective as of July 1, 1997, in the first paragraph, in cl. (a), in the first sentence, added two provisos, and inserted the second sentence.

Section 17 of St.1997, c. 43, in the first paragraph, added cl. (i).

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 3.

REFERENCES

CODE OF MASSACHUSETTS REGULATIONS

Disabled persons protection commission,
Advisory council, see 118 CMR 13.00.
Annual report, see 118 CMR 10.01 et seq.
Commissioner's investigations, see 118 CMR 6.01 et seq.
Definitions, see 118 CMR 2.00.
Interagency agreements, see 118 CMR 11.00.
Investigations, see 118 CMR 5.01 et seq.
Non-discrimination, see 118 CMR 12.00.
Petitions of incapacity, see 118 CMR 8.01 et seq.
Protective services, see 118 CMR 7.01 et seq.
Records, see 118 CMR 9.01 et seq.
Reporters, see 118 CMR 3.01 et seq.
Scope and authority, see 118 CMR 1.01 et seq.
Screening of reports and referrals to other agencies, see 118 CMR 4.01 et seq.

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§ 4. Referral of abuse reports

•Historical.Notes •References

Upon receipt of a report of abuse of a disabled person, the commission shall:--

(a) refer immediately any such reports which allege the occurrence of abuse that is subject to the provisions of sections fourteen to twenty-six, inclusive, of chapter nineteen A, sections seventy-two F to seventy-two L, inclusive, of chapter one hundred and eleven, or sections fifty-one A to fifty-one F, inclusive, of chapter one hundred and nineteen to the appropriate

agency for the implementation of measures provided in said sections.

(b) refer immediately any such reports, which allege the occurrence of abuse to a disabled person whose caretaker is a state agency, to an investigator of the commission and the general counsel of the office of the secretary of human services, or his designee, within such office and to the department within the executive office of human services which provides or which has contracted for the provision of services to the disabled person. As determined by the commission, either the commission or said department, subject to the oversight of the commission, shall investigate such abuse as provided in section 5. In all cases where a commission investigation is being conducted, the department shall take reasonable steps to avoid unnecessary unwarranted or counterproductive duplication between any internal investigation or inquiry by the department and the commission's investigation, by utilizing the commission's investigation in lieu of an internal investigation conducted by said department.

(c) refer immediately any such reports which allege the occurrence of abuse to a disabled person whose caretaker is other than a state agency to the general counsel or to the department of mental health, in those cases where the disabled person is mentally retarded or otherwise mentally disabled, or to the Massachusetts rehabilitation commission, in those cases where the disabled person is physically disabled and said counsel or the department of mental health or the department of public health shall immediately, upon such referral, designate an investigator who shall investigate such abuse as provided in section five.

Upon receipt of a report of abuse of a disabled person where the screener, in accordance with written standards established by the commission, determines that the report may contain allegations of criminal conduct, the screener shall immediately refer such report to the special investigative unit which shall conduct an initial evaluation and investigation of the alleged criminal conduct and, upon completion of such evaluation and investigation, shall report the results of such evaluation and investigation to the commissioners who shall, if the special investigative unit has determined that there is reason to believe that a criminal offense has been committed, immediately refer such report, together with any relevant information obtained in such initial investigation, to the attorney general or a district attorney for the county wherein the alleged criminal offense occurred. Upon receipt of such report, the attorney general or district attorney for the county wherein the alleged criminal offense occurred shall contact the commission in order to coordinate the investigation of the matters giving rise to the report. As part of such coordination, the attorney general or the district attorney may request that the commission delay or defer its investigation of the noncriminal matters giving rise to the report; provided, however, that such request shall be granted only where the commission determines that the health and the safety of clients of state agencies or of contract providers shall not be adversely affected thereby and that the commission's or department's ability to conduct a later investigation shall not be unreasonably impaired by such delay or deferral. In all cases including, but not limited to, those in which the commission agrees to delay or defer its investigation, the attorney general or district attorney shall keep the commission informed of the status of the criminal investigation and the commission shall provide to the attorney general or the district attorney any and all information that may be relevant to the criminal investigation. In cases in which the commission agrees to delay or defer its investigation, it shall monitor the progress of the criminal investigation and shall determine, after consultation with such law enforcement agencies, when or whether the commission's investigation should be initiated or resumed.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

1997 ELECTRONIC UPDATE

Amended by St.1997, c. 43, §§ 18, 19.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1997 Legislation

St.1997, c. 43, § 18, an emergency act, approved July 10, 1997, and by § 311 made effective as of July 1, 1997, in cl. (b), rewrote the second sentence, which prior thereto read, "Said department shall investigate such abuse as provided in section five, subject to the oversight of said office and the commission and subject to the power of the commission to conduct its own investigation.", and added the third sentence.

Section 19 of St.1997, c. 43, added the second paragraph.

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 4.

REFERENCES

LIBRARY REFERENCES

1997 ELECTRONIC UPDATE

Comments.

Social worker-client privilege, see Alperin and Shubow, 14B Massachusetts Practice § 13.100 (3d ed.).

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§ 5. Investigation and evaluation of abuse reports; disclosure of information; case findings and recommendations; reports of deaths

•Historical.Notes •References

Upon receipt of a report of abuse of a disabled person, an investigator designated by the commission, the general counsel, or a department within the executive office of human services shall:--

(1) Investigate and evaluate the information reported in said reports. Said investigation and evaluation shall be made within twenty-four hours if the commission, counsel or department of mental health or department of public health determines that there is reasonable cause to believe the disabled person's health or safety is in immediate danger from further abuse and within ten calendar days for all other such reports. The investigation shall include a visit to the disabled

person's residence and day program, if any, an interview with the disabled person allegedly abused, a determination of the nature, extent and cause or causes of the injuries, the identity of the person or persons responsible therefor and all other pertinent facts. Such determinations and evaluations shall be in writing and shall be immediately forwarded to the commission, to the general counsel and to the department of mental health and the department of public health.

If requested in writing by the commission or by any agency it designates, any mandated reporter required to make a report pursuant to section ten, shall disclose such documents relevant to any investigation being conducted pursuant to this chapter to the commission or to the agency. For the purposes of this section the word "documents" shall include, but not be limited to, any records, charts, reports, reviews, assessments, papers, correspondence and any other data or material.

Any privilege created by statute or common law relating to confidential communications or any statute prohibiting the disclosure of information shall neither preclude the disclosure of such documents to the commission or its designated agency nor prevent the admission of such documents in any civil or disciplinary proceeding arising out of the alleged abuse or neglect of the disabled person; provided, however, that absent the written consent of an individual to whom the requested documents relate, any information which is protected by the attorney-client privilege, the psychotherapist-client privilege, or the clergy-penitent privilege shall not be subject to such disclosure.

Any party required to provide documents in compliance with the provisions of this section shall not be liable in any civil or criminal action for providing such documents to the commission or any designated agency.

(2) Evaluate the environment of the facility named in the report, if any, and make a written determination of the risk of physical or emotional injury to any other residents or clients in the same facility.

(3) Forward to the commission, the general counsel, the department of mental health and the department of public health within a reasonable time after a case is initially reported pursuant to section four, a summary of the findings and recommendations on each case.

(4) If there is reasonable cause to believe that a disabled person has died as a result of abuse, immediately report said death to the commission, the general counsel, the attorney general, the district attorney for the county in which such death occurred, and to the medical examiner as required by section six of chapter thirty-eight.

(5) Not less than ten days prior to the issuance of a report containing a finding that there is reason to believe that misconduct has occurred, the commission shall provide written notice thereof to the person or persons alleged to have committed such misconduct and afford such person or persons the opportunity to respond in writing prior to the issuance of said report; provided, that, as determined by the commission, such notice of misconduct will not place the alleged victim at risk of further abuse.

Upon receipt of a report of abuse of a disabled person, or upon receipt of a written determination and evaluation prepared and forwarded to the commission pursuant to the provisions of this section, the commission, notwithstanding any provisions of chapter sixty-six A regarding personal data to the contrary, shall immediately report such conditions and forward said investigation and evaluation report, together with any other material or information which the commission has obtained or received and which is relevant to the alleged abuse, to the district

attorney for the county in which the abuse is alleged to have occurred if there is reasonable cause to believe that any of the following conditions exist: (a) a disabled person has been sexually abused or raped, or assaulted or battered, as set forth in chapter two hundred and sixty-five; (b) a disabled person has suffered brain injury, loss or substantial impairment of a bodily function or organ, or substantial disfigurement; or (c) a disabled person has suffered serious bodily injury as a result of a pattern of repetitive actions or inactions by a caretaker.

No person providing notification or information to a district attorney or providing testimony in court pursuant to the provisions of this section, shall be liable in any civil or criminal action by reason of such action.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11. Amended by St.1993, c. 429.

1997 ELECTRONIC UPDATE

Amended by St.1996, c. 220; St.1996, c. 450, § 35; St.1997, c. 43, § 20.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1996 Legislation

St.1996, c. 220, approved Aug. 2, 1996, added the second and third paragraphs.

St.1996, c. 450, § 35, an emergency act, approved Dec. 27, 1996, in par. (1), in the second paragraph, in the first sentence, substituted "commission or to" for "department or to".

St.1997, c. 43, § 20, an emergency act, approved July 10, 1997, and by § 311 made effective as of July 1, 1997, added par. (5).

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 5.

St.1993, c. 429, in par. (1), added the second to fourth paragraphs.

St.1993, c. 429, was approved Jan. 11, 1994. Emergency declaration by the Governor was filed on the same date.

REFERENCES

CROSS REFERENCES

Definition of victim includes a person who is subject of case reported under this section, see c. 258B, § 1.

§ 6. Protective services

•Historical.Notes

The commission, acting through state agencies within the executive office of human services designated by the commission, for the purpose of furnishing protective services, the general counsel acting through state agencies within the executive office of human services designated by the secretary of human services for the purpose of furnishing protective services, the department of mental health and the department of public health shall, as necessary to prevent further abuse in cases investigated by said commission, counsel or department:--

(1) furnish protective services to a disabled person either with his consent or with the consent of his current guardian;

(2) petition the court for appointment of a conservator or guardian or for issuance of an emergency order for protective services as provided in section seven; or

(3) furnish protective services to a disabled person on an emergency basis as provided in section seven.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 6.

§ 7. Petitions for findings of incapacity; emergency orders; warrants

•Historical.Notes

(a) If the commission, the general counsel, the department of mental health or the department of public health, has reasonable cause after initiation of an investigation to believe that a disabled person is suffering from abuse and lacks the capacity to consent to the provision of protective services, such commission, counsel or department may petition the court for a finding that the disabled person is incapable of consenting to the provision of protective services. Said petition shall set forth the specific facts upon which said commission, counsel or department relied in making such determination. The court shall hold a hearing on the matter within fourteen days of the filing of the petition. The court shall give notice to the disabled person who is the subject of the petition at least five days prior to the date set for the hearing. The disabled

person who is the subject of the petition shall have the right to be present, be represented by counsel, present evidence, and examine and cross-examine witnesses. If the disabled person who is the subject of the petition is indigent, the court shall appoint counsel to represent such disabled person. If the court determines that the disabled person lacks the capacity to waive the right to counsel, the court shall appoint a guardian ad litem to represent the interests of such disabled person. If, after hearing, the court determines, based upon a preponderance of the evidence, that such disabled person has been abused, is in need of protective services and lacks the capacity to consent and no other person who is authorized to consent is available or willing to consent, the court may appoint a conservator, guardian, or other person authorized to consent to the provision of protective services; provided, however, that the court shall establish the least restrictive form of fiduciary representation that will satisfy the needs of such disabled person. In addition to or in the alternative, the court may issue an order requiring the provision of services. The order shall contain a specific description of the services to be provided and insure that the least restrictive alternatives are utilized.

(b) If an emergency exists and said commission, counsel or department, a member of the immediate family or a caretaker has reasonable cause to believe that a disabled person is suffering from abuse and lacks the capacity to consent to the provision of protective services, said commission, counsel or department, member of the immediate family or caretaker may petition the court for an emergency order of protective services. The court shall give notice to the disabled person who is the subject of the petition at least twenty-four hours prior to the hearing. The court may dispense with notice upon finding that immediate and reasonable foreseeable physical harm to the individual or others will result from the twenty-four hour delay and that reasonable attempts have been made to give such notice. If after the hearing, the court determines, based upon a preponderance of the evidence, that the disabled person has been or is being abused, that an emergency exists, and that the disabled person lacks the capacity to consent to the provision of services, the court may order the provision of protective services on an emergency basis. The court shall order only those services necessary to remove the conditions creating the emergency and shall specifically designate the authorized services in its order. The order for emergency protective services shall remain in effect for a period not to exceed seventy-two hours. Said order may be extended for an additional seventy-two hour period if the court finds that such extension is necessary to remove the emergency.

(c) The court shall not order an institutional placement or change of residence unless it finds that no less restrictive alternative will meet the needs of the disabled person. No disabled person may be committed to a mental health facility pursuant to this section. The disabled person or his court appointed representative, said commission, counsel or department may petition to have any order issued pursuant to subsection (a) or (b) set aside or modified at any time.

(d) The courts of the commonwealth are hereby authorized to issue warrants for access to a disabled person upon application of the commission or any state or local law enforcement officer, where there is reasonable cause to believe that a disabled person is subject to abuse and access to such disabled person has been denied unreasonably to the commission or such law enforcement officers for the purpose of investigating the allegation of abuse.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

1997 ELECTRONIC UPDATE

Amended by St.1997, c. 43, § 21.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1997 Legislation

St.1997, c. 43, § 21, an emergency act, approved July 10, 1997, and by § 311 made effective as of July 1, 1997, added par. (d).

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 7.

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§ 8. Abuse of disabled persons under state care; investigations and hearings

•Historical.Notes

If, upon completion of investigation of a report of abuse of a disabled person whose caretaker is a state agency there is reasonable cause to conclude that such abuse did occur, or whenever, upon its own motion, the commission determines that a formal hearing is necessary to ascertain the scope and remedy of such abuse of disabled persons whose caretaker is a state agency, the commission may, upon a majority vote, initiate a formal investigation, including a hearing, to determine the nature and the extent of such abuse and what recommendations, if any, should be made with respect to such occurrence. Testimony in commission proceedings may, in the discretion of the commission, be recorded and taken under oath. The commission may, in its discretion, permit any party to testify, to call and examine witnesses, to introduce evidence or to cross-examine witnesses. Before testifying, all witnesses shall be given a copy of the regulations governing the commission proceedings. Each witness shall be entitled to be represented by counsel and may refuse to submit evidence or give testimony if such evidence or testimony could tend to incriminate him. All proceedings of the commission shall be public unless the commission votes to go into executive session. Any person whose name is mentioned during a proceeding under this section and who may be adversely affected by any action of the commission under section nine shall have the right to appear personally, to be represented by counsel in connection with the proceedings, to call and examine witnesses, to introduce evidence or to cross-examine witnesses.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 8.

§ 9. Completion of hearings; reports; referrals

•Historical.Notes •References

Upon the completion of any formal investigation, the commission shall:--

(a) issue a written report and refer the same to the appropriate state agency. Such report shall contain findings of fact concerning the alleged occurrence of abuse that was the subject of the investigation, together with a finding as to whether or not such abuse did occur and, if so, what actions are necessary to remedy the causes of such abuse or to prevent its reoccurrence;

(b) refer any matters for which there is reason to believe that a crime has been committed to the attorney general, the United States attorney or a district attorney for the county wherein such crime was committed;

(c) refer any matters for which there is reason to believe that employee misconduct has occurred to the state agency employing such person for imposition of disciplinary measures in accordance with the requirements of any applicable law, regulation or collective bargaining agreement; or

(d) refer any matters for which there is reason to believe that misconduct has occurred by a contractor with a state agency or by such contractor's agent, to the state agency contracting with such party for termination of such contract or for such other action as may be deemed appropriate by such state agency.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 9.

REFERENCES

CROSS REFERENCES

Definition of victim includes a person who is subject of case reported under this section, see c. 258B, § 1.

§ 10. Reporters of abuse; liability; privileged communications

•Historical.Notes

Except when prevented by the constraints of professional privilege as hereinafter provided, mandated reporters shall notify the commission orally of any reportable condition immediately upon becoming aware of such condition and shall report in writing within forty-eight hours after such oral report.

Mandated reporters who have reasonable cause to believe that a disabled person has died as a result of a reportable condition shall immediately report such death, in writing, to the commission, to the district attorney for the county in which such death occurred and to the medical examiner as required by section six of chapter thirty-eight.

Any person may file report [FN1] if such person has reasonable cause to believe that a disabled person is suffering from abuse or has died as a result thereof.

No mandated reporter shall be liable in any civil or criminal action by reason of submitting a report. No other person making a report shall be liable in any civil or criminal action by reason of submitting a report if such report was made in good faith; provided, however, that no person who abuses a disabled person shall be exempt from civil or criminal liability by reason of their reporting such abuse.

No privilege established, by sections one hundred and thirty-five A and one hundred and thirty-five B of chapter one hundred and twelve, by section twenty or twenty B of chapter two hundred and thirty-three, by court decision or by professional code relating to the exclusion of confidential communications and the competency of witnesses may be invoked to prevent a report by a mandated reporter or in any civil action arising out of a report made pursuant to this chapter; provided, however, that a mandated reporter need not report an otherwise reportable condition if the disabled person invokes a privilege, established by law or professional code, to maintain the confidentiality of communications with such mandated reporter.

Any person required by this section to make oral and written reports, who fails to do so, shall be punished by a fine of not more than one thousand dollars.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11. Amended by St.1989, c. 535, § 3.

[FN1] So in original.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 10.

St.1989, c. 535, § 3, approved Nov. 17, 1989, in the fifth paragraph, substituted "sections one hundred and thirty-five A and one hundred and thirty-five B" for "section one hundred and thirty-five".

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§ 11. Retaliation for reporting abuse

•Historical.Notes

No person shall discharge or cause to be discharged or otherwise discipline or in any manner discriminate against or threaten any employee, client or other person for filing a report with the commission or testifying in any commission proceeding, or providing information to the commission, the general counsel or the secretary of human services, the department of mental health or the department of public health or any department within the executive office of human services in the course of an investigation of alleged abuse of a disabled person. Any person who willfully violates the provisions of this section shall be punished by a fine of not more than one thousand dollars or by imprisonment for not more than one year, or both. The commission shall enforce the provisions of this section.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 11.

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§ 12. Scope of chapter; delay or deferral of investigation

•Historical.Notes

Nothing in this chapter shall be construed to be a limitation of the powers and responsibilities assigned by law to other departments or agencies, nor shall this chapter be construed to relieve any such department or agency of its obligations to investigate and respond appropriately to alleged incidents of abuse. If the commission determines that a formal investigation under section eight, or an investigation under sections four and five, would

duplicate or interfere with an ongoing investigation by law enforcement officials concerning possible criminal conduct arising out of the same conduct, it may, in consultation with the secretary of human services, delay or defer such formal investigation. The commission may, in consultation with the secretary of human services, delay or defer a formal investigation during the pendency of an investigation of the alleged abuse by the state agency at whose facility or program such abuse was alleged to have occurred. Such investigations may be delayed or deferred by the commission only after it has determined: that the health and the safety of clients of state agencies will not be adversely affected thereby; that the commission's ability to conduct a later investigation will not be unreasonably impaired and that the investigation of the incident by another official or agency will be conducted in good faith by an impartial, qualified investigator. The commission shall monitor the progress of such other investigations in order to determine when or whether the commission's investigation of the alleged incident of abuse should be initiated or resumed.

CREDIT(S)

1994 Main Volume

Added by St.1986, c. 655, § 1. Renumbered by St.1987, c. 465, § 11.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1994 Main Volume

St.1987, c. 465, § 11, an emergency act, approved Nov. 3, 1987, renumbered the provisions of this section from c. 19B, § 12.

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§ 13. Notification by caretaker agency of death of disabled person; written report

•Historical.Notes

Upon the death of any disabled person whose caretaker was a state agency or an agency of any subdivision of the commonwealth or a private agency contracting with the commonwealth, said caretaker agency shall immediately orally notify the commission and local law enforcement officials of such death, and shall forward to the commission and local law enforcement officials a written report of such death within twenty-four hours of the death. Said report shall contain the name of the disabled person, the name of the facility in which that person resided, and the facts and circumstances of the death. The commission shall take all appropriate measures regarding the report pursuant to its authority under this chapter, including investigating the death, and shall determine whether the cause of death is related to abuse. If it is determined that the death is related to abuse, the commission shall conduct further investigation, or shall oversee further investigation, pursuant to the provisions of this chapter.

CREDIT(S)

1997 ELECTRONIC UPDATE

Added by St.1995, c. 38, § 34.

HISTORICAL NOTES

HISTORICAL AND STATUTORY NOTES

1997 ELECTRONIC UPDATE

1995 Legislation

St.1995, c. 38, § 34, was approved June 21, 1995, and by § 358 made effective July 1, 1995.

115 CMR 9:00: INVESTIGATIONS AND REPORTING RESPONSIBILITIES

Section

9.01: Scope, Authority and Purpose

(1) Scope.

(a) 115 CMR 9.00 applies to all offices of the Department and all programs and services operated, licensed or contracted by the Department.

(b) Any decision made pursuant to 115 CMR 9.00 shall be consistent with bargaining agreements and other provisions of labor law then in effect.

(2) Authority. 115 CMR 9.00 is adopted by the Department pursuant to M.G.L. c. 19B, §§ 1, 10, and 14, c. 123B, §§ 2 and 14, and c. 19C.

(3) Purpose. 115 CMR 9.01 through 9.04 is promulgated to promote the reporting and thorough investigation of allegations of incidents or conditions alleged to be illegal, dangerous or inhumane, and suspicious deaths, and other matters investigated pursuant to 115 CMR 9.00. If such allegations are substantiated, 115 CMR 9.01 through 9.04 is intended to provide for swift rectification of any conditions causing or contributing to the matter.

(a) 115 CMR 9.00 does not provide for an adjudicatory hearing within the meaning of M.G.L. c. 30A, § 1(1). 115 CMR 9.00 is not intended to constitute an administrative remedy under the doctrine of exhaustion of administrative remedies or otherwise.

(b) 115 CMR 9.00 is not a vehicle for complaints against individuals who have challenging behaviors addressed in their ISP, except where another individual is or potentially will be seriously harmed thereby.

9.01: continued

(c) 115 CMR 9.00 shall only apply to particular matters affecting the rights of individuals.

(4) Director of Investigations. There shall be a Director of Investigations responsible for overseeing the implementation of 115 CMR 9.00. Such Director shall have the authority to review all documentation received and generated by the Investigations Unit.

9.02: Definitions

For purposes of 115 CMR 9.00 *only*, the following terms shall have the following meanings:

Complainant means any person who files a complaint under 115 CMR 9.00.

Complaint means an allegation communicated to the Department of an incident, condition or other occurrence which meets any of the criteria set forth in 115 CMR 9.05, regardless of whether the allegation is also required to be reported to the DPPC under M.G.L. c. 19C.

Dangerous means poses or posed a danger or the potential of danger to the health and safety of an individual regardless of whether injury resulted.

Day means a working day and therefore shall exclude Saturdays, Sundays and legal holidays in the Commonwealth.

DPPC means the Disabled Persons Protection Commission.

Frivolous means utterly devoid of merit. All complaints filed pursuant to 115 CMR 9.05 through 9.14 are presumptively non-frivolous unless the senior investigator determines that the complaint

(a) involves matters not within the scope of the Department's regulations, 115 CMR;
(b) is clearly impossible on its face; or
(c) asserts identical allegations to a complaint previously filed concerning the same parties and allegedly occurring at the same time, and that have proven to be unsubstantiated.

General Counsel means the person serving as chief legal counsel to the Commissioner as set forth in M.G.L. c. 19B, § 5.

Incapable means:

(a) Having been determined in one's latest ISP to be incompetent in fact to make informed decisions in specific areas regarding the conduct of one's personal or financial affairs; or
(b) Otherwise deemed by the human rights committee notified under 115 CMR 9.07(2) to be unable to effectively draft a written complaint, understand the complaint procedure, or effectually participate in the complaint process.

9.02: continued

Inhumane means something that is or was demeaning to an individual or inconsistent with the proper regard for human dignity.

Medicolegal Death means:

(a) a death of any individual if the Medical Examiner takes jurisdiction;
(b) death that appears to have resulted from unusual or suspicious circumstances;
(c) death which may have been caused by violence, including sexual abuse; or
(d) any other death required by M.G.L. c. 38, § 6, to be reported to the Medical Examiner.

Party means:

(a) the complainant;
(b) the person or persons complained of or thought or found to be responsible for any incident or condition subject to investigation;
(c) the guardian of the complainant or person complained of, if any;
(d) any other individual harmed (or reasonably believed to be harmed) as a result of the incident or condition, and his or her guardian, if any;
(e) the human rights committee of the involved provider.

9.03: Notice of 115 CMR 9.00

The regional, case management, or facility director, as applicable, shall have responsibility for enforcing the following:

(1) Notice of 115 CMR 9.00 is included in information posted by every provider or otherwise provided to every individual served or his or her guardian, if any, within 30 days after the effective date of 115 CMR 9.00;

(2) Every new resident of a Department-operated facility or a community-based residential program, or his or her guardian, if any, is notified upon admission of the existence of 115 CMR 9.00 and of his or her right to file a complaint under 115 CMR 9.00;

(3) Such notification and blank copies of the forms for complaint and appeal under 115 CMR 9.00 are posted in a prominent place in plain sight in every unit of every facility, at every regional and case management team office; and at every community day and residential program; and

(4) Such notification, forms, and copies of 115 CMR 9.00 are available at the facility, program, or case management team upon request by any person at any time.

9.04: Orientation and Training

(1) All providers and directors shall provide to all service coordinators and direct contact staff working under their supervision an initial and subsequent, periodic orientation on the purpose and principal provisions of 115 CMR 9.00. Training shall include the Department's standard Abuse Protocol.

(2) All providers shall provide to all individuals served an initial and subsequent, annual training on when and how to file a complaint or obtain assistance under 115 CMR 9.00. Such training shall include use of alternative means of communication where the individual is hearing or speech impaired or unable to communicate without assistance or an interpreter.

(3) The Department shall provide initial and periodic training to all investigators in investigatory techniques, confidentiality issues and contemporary modes and principles of service delivery. Investigators shall not conduct investigations unless they have been trained in accordance with 115 CMR 9.04.

(4) Only individuals hired by the Department as investigators shall conduct investigations, with the exception of such individuals as may be designated by the Commissioner or designee to conduct an investigation pursuant to 115 CMR 9.14(6). No individual hired by the Department as an investigator shall be made or permitted to undertake any additional job responsibilities not directly related to conducting investigations or preparing investigation reports and recommendations.

9.05: Scope of Responsibilities of the Department's Investigations Unit

(1) The Department's Investigation Unit shall investigate or otherwise determine the merit or facts of any of the following, in accordance with 115 CMR 9.05 through 9.14:

(a) Any non-frivolous complaint of any other condition or incident involving an individual served by the Department which is

1. mistreatment;
2. illegal;
3. dangerous; or
4. inhumane.

(b) Medicolegal deaths of individuals served by the Department unless investigated by another authorized agency, except that the Director of Investigations may determine that investigation by the Department of such medicolegal deaths is in the best interest of the public or of the Department.

(c) Any matter for which the Commissioner or designee determines that investigation is warranted as in the best interests of an individual served by the Department, or in the best interests of the public or the Department.

(2) Notwithstanding 115 CMR 9.05(1), the following shall be deemed to be outside the scope of the Investigations Unit's responsibilities:

9.05: continued

(a) Allegations about the need for or appropriateness of services for an individual which the Senior Investigator determines can be resolved through the service planning (ISP) process, shall be addressed pursuant to the ISP regulations, 115 CMR 6.00.

(b) Allegations about violations of program standards set forth in 115 CMR 7.00 which the Senior Investigator determines can be resolved through the licensing process, shall be addressed pursuant to regulations governing licensing inspections, 115 CMR 8.00.

9.06: Filing of Complaint

(1) Any individual or the human rights committee of any provider may file a complaint by communicating the complaint to the senior investigator for the region.

If asked to do so by an individual, a Department or provider employee shall assist the individual in making an oral or written complaint to the senior investigator or shall direct the individual to the appropriate staff who shall assist the individual in making an oral or written complaint.

(2) A Department or provider employee is mandated to and shall immediately file a complaint under 115 CMR 9.00 with the senior investigator for the region when he or she has reason to believe that there is a non-frivolous allegation of mistreatment, an illegal, dangerous, or inhumane condition or incident, or a medicolegal death of an individual. Failure to so file shall be grounds for appropriate disciplinary action. Where the employee has reason to believe that *serious physical or emotional injury resulted* to an individual from an act or omission by a caretaker, he or she is also mandated to file a report with the DPPC under M.G.L. c. 19C. A "caretaker" is the individual's parent, guardian, provider staff or other person or agency responsible for the individual's health or welfare, whether in the same home as the individual or any other day or residential setting.

(3) The senior investigator shall take steps to make certain that any complaint is accurately and completely reduced to writing on a complaint form.

(4) If the senior investigator concludes at any time during the course of the investigation that immediate action is necessary to protect the safety of welfare of an individual involved in the complaint, he or she shall immediately communicate, orally and in writing, the nature of the allegations and the identity of the alleged victim and the alleged abuser (if applicable) to the regional director, and the case management team director, or facility director.

(a) The Regional Director or designee shall notify the provider, who shall be responsible for taking immediate action;

(b) The head of any provider notified of a complaint alleging any physical abuse including any sexual activity between an individual and an employee of the provider shall immediately remove such employee from all direct contact responsibilities pending resolution or investigation of the complaint.

9.07: Logging and Disposition of Complaint

(1) Logging. When the complaint is filed, the senior investigator shall immediately log the complaint and assign its log number upon receipt.

(2) Notice of Complaint to Human Rights Committee Chair. In all cases, the senior investigator shall send a copy of the complaint and any investigator appointment to the chairperson of the appropriate human rights committee within three days of logging. The names of the reporter and the alleged abuser shall be redacted from the copy of the complaint so forwarded.

(3) Determination of Disposition.

(a) No later than three days after receipt of the complaint, the senior investigator shall determine, and set forth in a written Disposition Letter, whether the complaint shall be

1. dismissed;
2. resolved without investigation;
3. referred for resolution to the regional director as beyond the scope of the responsibilities of the Investigations Unit;
4. designated as requiring investigation but deferred pending investigation by outside authorities.
5. assigned to an investigator for active investigation; or

(b) A matter complained of may be resolved through a combination of dispositions.

(c) The senior investigator shall send a copy of the Disposition Letter to the regional director, the case management team director or facility director, the complainant, and the chairperson of the Human Rights Committee for any provider involved, and shall note the manner of disposition in the log. A copy of the complaint, from which the names of the reporter and alleged abuser have been redacted, shall also be sent to the chairperson of the Human Rights Committee.

(d) The regional director or designee shall notify the alleged victim, and the guardian of the alleged victim and the family unless the alleged victim knowingly objects.

(4) Dismissal. A complaint may be dismissed where:

(a) it is frivolous;

(b) the allegations were previously investigated and no new facts or evidence have materialized; or

(c) the matter alleged is not within the scope of 115 CMR 9.05.

Where a complaint has been dismissed, the Disposition Letter required by 115 CMR 9.07(3)(a) shall set forth the reasons for the dismissal.

(5) Expedited Resolution. A complaint may be resolved by the Investigations Unit without investigation if the matter complained of involves no dispute as to the facts, or may be resolved fairly and efficiently within a five day period.

9.07: continued

(6) Referral for Resolution to Regional Director. The senior investigator shall refer the matter alleged to the regional director for resolution where:

(a) the matter alleged falls outside the scope of 115 CMR 9.05(1), but falls within the scope of other of the Department's regulations; or

(b) the matter falls within the scope of 115 CMR 9.05(1), but

1. appears to be or is alleged to be the result of implementation of, or the failure to implement, an individual's ISP; or

2. concerns or alleges program conditions that are in violation of the Department's regulations on program standards, 115 CMR 7.00;

provided that, if the matter involves an allegation of a medicolegal death it shall be retained by the Investigations Unit for disposition by some manner other than referral to the regional director.

(c) Within 14 days of receipt the Regional Director shall notify the complainant of how the matter will be addressed.

(d) All complaints which are disposed of in this manner must be logged at the time of filing.

(7) Assignment of Investigator. If the senior investigator determines that the matter complained of cannot be fully resolved without investigation, the senior investigator shall, no later than 24 hours after receiving the complaint, prepare a written, dated appointment of an investigator (who, in the judgment of the senior investigator, is capable of proceeding with the investigation in an impartial and objective manner but who shall not be any of the persons directly involved in the incident or condition requiring investigation). The senior investigator shall upon appointment give the case file to the investigator.

(a) Change in Disposition. If after commencing the investigation in accordance with 115 CMR 9.08, the investigator determines that the complaint requires a disposition other than such investigation, he or she shall return the investigation file to the senior investigator, within 1 day of reaching such determination, together with a memorandum supporting the recommended change in disposition.

1. The senior investigator must determine within one day of receiving the investigation file and memorandum whether a change in disposition is warranted.

2. Any resulting change in disposition shall be noted in the log and generate a Change in Disposition Letter. Such Change in Disposition Letter shall be issued and sent to the parties and any human rights committee previously notified no later than one day after the senior investigator receives the investigation file and memorandum.

(8) Deferral of Investigation. If the matter has also been reported to the DPPC in accordance with 115 CMR 9.16, or has been reported to and is being investigated by criminal justice or other outside authorities, the senior investigator may determine that the Department's investigation pursuant to 115 CMR 9.08 shall be deferred pending completion of the DPPC investigation pursuant to M.G.L c. 19C or the other authorities. The decision to defer an investigation shall be made in accordance with 115 CMR 9.14(7).

9.08: Conduct of Investigation

(1) Training Manual. All investigations shall be conducted in accordance with 115 CMR 9.08 and with any standards for the conduct of investigations set forth in the Department's training manual for investigators, as approved by the Director of Investigations.

(2) Interviews.

(a) The investigator shall hold a private, face-to-face interview to discuss the complaint with the following individuals, preferably, but not necessarily, in the following order:

1. the complainant; however, where the complainant is the victim, the investigator may conclude that under the circumstances interview of the complainant would cause further harm and therefore shall not occur;
2. the victim, if not the complainant; however, the investigator may conclude that under the circumstances interview of the victim would cause further harm and therefore shall not occur;
3. any known eye-witnesses to the matter alleged;
4. any other person the investigator deems appropriate;
5. the person(s) complained of or thought to be responsible for the matter alleged.

(b) In scheduling face-to-face interviews (and again at the interview but only with respect to the person being interviewed), the investigator shall inform the person to be interviewed and his or her guardian, if any (unless the guardian is the person complained of or the individual otherwise objects:

1. of the existence of the complaint, the general nature of the allegations and his or her role as the investigator; but the investigator shall not inform the person to be interviewed of the identity of the complainant;
2. that he or she may be represented by one of the following: an attorney, legal advocate, union representative, or competent lay person of his or her own choice who is 18 years or older and who is not otherwise involved in the investigation;
3. that he or she has an obligation to cooperate in the investigation and that failure to cooperate may result in disciplinary action, including termination, or in departmental action adverse to the provider.

(c) Whenever a person refuses to be interviewed, the investigator shall set forth such refusal in the investigation report. If the investigator does not interview the victim for reason other than refusal to be interviewed, the investigator shall set forth in the investigation report the reasons why such interview did not occur, including the basis for any determination that the interview would cause harm.

(3) Review of Pertinent Documents. As part of the investigation the investigator shall review and shall have the right to obtain copies thereof, all pertinent documents, including, but not limited to:

(a) medical or clinical records pertaining to any injury, if obtainable;
(b) any incident report filed pursuant to 115 CMR 9.15;
(c) relevant portions of the case records of any individual served and involved in the allegations;
(d) any restraint forms completed in connection with the matter under investigation:

9.08: continued

(e) relevant personnel records;
(f) any relevant policies, procedures or guidelines of the Department and the provider involved or employer of the person complained of;
(g) photographs of any injury or property damage, if taken;
(h) previous related cases complained of or investigated pursuant to M.G.L. c. 19C or 115 CMR 9.05 through 9.14;
(i) any other document deemed appropriate by the investigator, if obtainable.
Providers shall make all records available to the investigator.

(4) Site Visit. The investigator shall visit and inspect the site where the matter to be investigated occurred or exists, as a means of gathering additional evidence and gaining a better understanding of the context of the allegations.

(5) Additional Inquiries. The investigator may employ such other investigatory techniques as deemed appropriate in his or her professional judgment under the circumstances, including consultation with clinical experts.

9.09: Issuance of Decision Letter

(1) Immediate Protective Action. Prior to completion of the investigation and the issuance of the Decision Letter, the senior investigator shall notify the regional director by phone and in writing when, in his or her judgment, the information uncovered in the course of the investigation warrants immediate interim action to protect the safety, dignity, or welfare of the individual(s) involved. The director shall take or require such action as necessary for the immediate safety, dignity, or well-being of the individual(s).

(2) Time Line for Issuance of Decision Letter.
(a) For complaints concerning individuals, staff, or conditions at any of the facilities or Department operated ICF's/MR, the results of all investigations must be reported to the regional director within five days of the incident or condition, in accordance with the requirements of Title XIX of the Social Security Act.
(b) For all other complaints, the results of all investigations must be reported and a Decision Letter delivered to the regional director, and case management team or facility director, within 30 days of the investigator's appointment. The immediately foregoing provision does not apply to investigations conducted by the Department on behalf of the DPPC, the initial responses of which must be reported to the DPPC and to the regional director and CMT or facility director within ten days. However, a Decision Letter must be delivered to the relevant officials within 30 days of the investigator's appointment to conduct an investigation under 115 CMR 9.00, regardless of any DPPC investigation.

(3) Preparation of Decision Letter.
(a) For matters that are investigated.

9.09: continued

1. Upon completion of the investigation, the investigator shall prepare and deliver to the senior investigator an investigation report, which shall, when adopted as the official investigation report, serve as the basis for the Decision Letter.

a. The investigation report shall describe the investigation and contain the investigator's findings of fact and conclusions.

b. The senior investigator shall review the investigation report for thoroughness, accuracy, and quality.

c. The senior investigator's signature on the investigation report signifies that the report has been officially adopted as thorough, accurate, and of acceptable quality.

d. The senior investigator may conclude that an investigation report prepared as part of a DPPC investigation or as part of an investigation by other outside authorities thoroughly and accurately addresses all the issues raised by the allegations and may be adopted as the Department's own official investigation report.

2. No later than 30 days after assignment of the investigator, the senior investigator shall send a dated Decision Letter, bearing the senior investigator's signature, and an investigation report to the regional director, and the case management team director or facility director.

3. The Decision Letter shall summarize the complaint, the evidence considered by the investigator and the findings of facts and conclusions contained in the official investigation report.

4. The Decision Letter is separate and apart from any letter or report required by M.G.L. c. 19C to be forwarded to the DPPC.

(b) For Matters Resolved by Expedited Resolution.

1. Within six days after receipt of a complaint resolved by expedited resolution, the senior investigator shall issue a dated Decision Letter, bearing the senior investigator's signature, to the regional director, and the case management team director or facility director.

2. The Decision Letter shall summarize the complaint, the undisputed facts of the matter and the senior investigator's conclusions as to what occurred.

(c) Investigations of Medicolegal Deaths. In the case of a medicolegal death, a copy of the official investigation report and the Decision Letter shall also be submitted to the General Counsel and the Commissioner.

9.10: Issuance and Implementation of Action Plan

(1) Designation of Staff Person. The regional director or his or designee shall designate the staff person responsible for preparing and overseeing implementation of an Action Plan. The designation shall be made within two days of the regional director's receipt of the Decision Letter.

9.10: continued

(2) Preparation and Issuance of Action Plan. Within ten days of being designated, the designated staff person shall review the Decision Letter and the investigation report, or the Disposition Letter, discuss the matter with any of the persons involved whom he or she may think appropriate, and prepare and formally issue a written, signed and dated Action Plan.

(a) Where the matter has been investigated by the Department or an outside authority, such Action Plan shall:

1. state the specific actions to be taken in response to the Decision Letter, the date(s) such action are to be implemented and the person(s) responsible for implementation;
2. notify the parties of their right to request reconsideration under 115 CMR 9.10(6) and their right of appeal under 115 CMR 9.11.

(b) Where the matter has been resolved by expedited resolution, such Action Plan shall:

1. state the specific actions to be taken, if any to address the matters raised in the complaint, the date(s) such action are to be implemented and the person(s) responsible for implementation;
2. notify the parties of their right to request reconsideration under 115 CMR 9.10(6) and their right of appeal under 115 CMR 9.11.

(3) Distribution of Action Plan and Decision Letter.

(a) The designated staff person shall, within one day of completion of the Action Plan, send copies of the Action Plan and the Decision Letter to:

1. the parties, (or their representatives, if any); with a notice of the opportunity to request reconsideration pursuant to 115 CMR 9.10(6) and a notice of appeal rights;
2. the head of any provider responsible for implementing the Action Plan;
3. the human rights committee of the provider;
4. any service coordinator assigned to the individual;
5. the Director of Investigations; and
6. the Division of Quality Assurance of the Department's Office of Quality Enhancement.

(b) The designated staff person shall also send a copy of the Action Plan to the regional director, case management team director or facility director, senior investigator and investigator.

(c) Where the matter has been investigated, the senior investigator shall provide to the parties a copy of the official investigation report, with identifying information redacted, in accordance with M.G.L. c. 66A, within five days of receipt of a request.

(4) Request for Reconsideration. Any party aggrieved by the Action Plan or the Decision Letter, may, within five days of receipt of the Action Plan, file a request for reconsideration with the regional director, specifying how the Action Plan or Decision Letter is deficient. The regional director shall send a copy of the request to the designated staff person, the Senior Investigator, and all other parties.

(a) Receipt of the Action Plan will be presumed to have occurred within seven days of mailing.

9.10: continued

(b) Upon receipt of a request for reconsideration, the regional director shall consider the deficiencies alleged, proceeding as if he or she has just received the Decision Letter as provided in 115 CMR 9.09(3)(b).

(5) Implementation of Action Plan. Any individual or provider required to implement corrective action or protective services set forth in the Action Plan shall provide documentation to the designated staff person that the corrective action or protective services have been implemented in accordance with the time-lines set forth in the Action Plan. The designated staff person is responsible for enforcing this provision.

9.11: Appeal

(1) Grounds for Appeal.

(a) Any party, except an employee who chooses to grieve a matter as specified in 115 CMR 9.11(3), may appeal the following on any of the grounds stated in 115 CMR 9.11(1)(b):

1. a disposition other than assignment of an investigator or deferral of investigation pending investigation by outside authorities;
2. the Decision Letter; or
3. the Action Plan.

(b) The grounds for appeal shall be as follows:

1. The disposition selected was not in accordance with 115 CMR 9.07;
2. The Decision Letter is based on an investigation which was not conducted in accordance with 115 CMR 9.08;
3. The Decision Letter is based on an investigation report that does not comply with 115 CMR 9.09(3)(a)1.;
4. The Decision Letter reaches conclusions not supported by the official investigation report;
5. The Decision Letter fails to reach conclusions compelled by the official investigation report;
6. The Decision Letter reaches conclusions not supported by the undisputed facts;
7. The Decision Letter fails to reach conclusions compelled by the undisputed facts;
8. The investigation report on which the Decision Letter rests contains findings that are not supported by the weight of the evidence;
9. The Action Plan does not sufficiently assure the safety, dignity or welfare of the individual(s) involved in the complaint;
10. The Action Plan calls for action which is not supported by the Decision Letter and which is to the detriment of any person involved in the complaint;

9.11: continued

(2) Appeal Procedure.

(a) Any party, except an employee who chooses to grieve the matter as specified in 115 CMR 9.11(3), who is aggrieved by the manner of disposition of a complaint, by the Decision Letter or by the Action Plan may, within ten days of receipt of the Action Plan, denial of a request for reconsideration, or a determination after reconsideration (whichever is later) file a notice of appeal with the Commissioner.

1. Receipt of decisions which may be appealed will be presumed to have occurred within seven days of mailing.

2. Notices of appeal filed prior to issuance of the Action Plan become valid only upon issuance of the Action Plan.

(b) Within three days of receiving a valid notice of appeal, the Commissioner shall send a copy of the notice to the senior investigator, who shall, within one day of receiving it, send copies of the notice to the other parties and their representatives, and to the regional director, the designated staff person and the investigator.

(c) Within three days of receiving the notice of appeal, the senior investigator shall forward the entire case file to the Commissioner.

(d) Within 30 days of receiving the case file the Commissioner shall review the notice and the investigation file, discuss the matter with any of the persons involved whom he or she may think appropriate, and prepare and distribute a written, dated Appeal Decision which shall do any combination of the following:

1. Affirm or reject the manner of disposition, with a statement of reasons, and, if appropriate, specify a different manner of disposition;

2. Affirm, modify or reject the Action Plan, with a statement of reasons. The regional director shall then deliver an Addendum to the Action Plan to the Commissioner within the following five days. Upon receipt thereof, the Commissioner shall proceed as provided above in 115 CMR 9.11(2)(c), except that he or she shall make and distribute his or her decision within five days of receipt of the Addendum.

3. Affirm the Decision Letter in whole or in part with respect to the findings or conclusions contained therein, with a statement of reasons;

4. Reject any findings or conclusions contained in the Decision Letter, with a statement of reasons.

a. The Commissioner may send the matter back to the investigator for further investigation where appropriate. In that event, the Commissioner shall so notify the senior investigator, who is then responsible for seeing that the further investigation is completed.

b. Where the matter has been sent back for further investigation, the senior investigator is responsible for seeing that an Addendum to the Decision Letter is delivered to the regional director the 15 days following receipt of receipt of the Commissioner's decision. The regional director is then responsible for seeing that an Addendum to the Action Plan as necessary to reflect the Addendum to the Decision Letter are delivered to the Commissioner within the following five days.

9.11: continued

c. Where the Commissioner rejects any portion of the Decision Letter but does not require further investigation, the regional director is responsible for delivering an Addendum to the Action Plan to the Commissioner within the following five days.

d. Upon receipt of any Addenda, the Commissioner shall proceed as provided above in 115 CMR 9.11(2)(c), except that he or she shall make and distribute his or her decision within five days of receipt of the Addenda.

e. Each party and his or her chosen representative shall be invited to any informal inquiry convened by the Commissioner.

f. The Commissioner shall distribute copies of his or her decision to the parties, and to the regional director and the senior investigator, and shall also return the case file to the senior investigator.

g. All corrective actions and protective services required by the Action Plan shall be implemented pending appeal.

h. The decision of the Commissioner shall be final.

(3) Any employee who is a party aggrieved by the manner of disposition of a complaint, by the Decision Letter or by the Action Plan, and who has a right to a hearing under a collective bargaining agreement or civil service law, may grieve the matter as specified therein. Where the employee elects such procedures, they shall be the exclusive procedures for resolving the employee's grievance. The invocation of such procedures shall not alter the Department's responsibility under 115 CMR 9.00 to respond to, investigate, and make decisions concerning complaints and appeals initiated by or concerning individuals it serves.

9.12: Role of Human Rights Committee

(1) Responsibilities for Incapable Individuals or Individuals Who Require Assistance to Communicate.

(a) The human rights committee shall use its best effort to see that an incapable individual, or an individual determined in his or her latest ISP to be unable to communicate without assistance or an interpreter, who is involved in the complaint is represented by an independent attorney or advocate, if necessary or appropriate, in order to ensure that his or her interests are adequately protected. A list of such attorneys or advocates shall be maintained by the human rights committee and made available to any individual when requested.

Where the human rights committee fails to act to obtain representation for an individual or to advocate on his or her behalf, the investigator may request the assistance of the service coordinator in ascertaining the capability of the individual and seeking an attorney or advocate to represent the individual.

(b) At the request of an individual, or on its own motion, where appropriate, the human rights committee shall assist an individual in filing a complaint.

9.12: continued

(2) Party to Complaints or Proceedings. The human rights committee of a provider shall be a party to all complaints involving individuals served by the provider, and, as such, it shall receive copies of all reports, appeals, notices and other significant documents relevant to the resolution of the complaint and be able to appeal any finding or decision on the grounds that there has been a violation of 115 CMR 9.05 through 9.14.

(3) Human Rights Committees shall treat as confidential all information and documents which they receive in their capacity as a party.

9.13: Records, Forms and Notices

(1) Case File.

(a) Contents of Case File. A file, known as the case file shall be kept for each complaint received by the Department. The case file shall include:

1. the complaint and the public log number assigned;
2. the Disposition Letter;
3. a copy of the memorandum appointing the investigator;
4. the names of all persons interviewed and the dates of those interviews;
5. either taped or written interviews or summaries thereof;
6. a summary of documents reviewed;
7. copies of notes or memoranda generated by the investigation;
8. a copy of the official investigation report; and any such report shall be admissible in any employee disciplinary hearing related to the investigation;
9. the Decision Letter;
10. the Action Plan;
11. documentation of corrective action or protective services implemented; and
12. all documents relating to any appeal.

(b) Confidentiality. Any person who is mentioned in the case file shall have access to, and may have a copy of, that portion of the record in which he or she is mentioned, consistent with the Fair Information Practices Act, M.G.L. c. 66A, § 2(i).

1. Union representatives or legal representatives (in their representative capacity) may obtain a redacted copy of the official investigation report for a scheduled disciplinary, grievance, or appeal inquiry, upon presentation of written authorization from the employee for release.

2. The Commissioner may determine that publicity accorded the investigation is so extensive that mere removal of identifying data would be insufficient to protect existing privacy interests, or that disclosure would probably so prejudice the possibility of an effective investigation by law enforcement agencies that such disclosure would not be in the public interest. In such event, the Commissioner shall file in the case file a statement of this determination, with a specification of the document(s) to be withheld as an exemption to the definition of public records set forth in M.G.L. c. 4, § 7, cl. 26, and the conditions of withholding and a brief statement of reasons. Such withholding shall be governed by the Fair Information Practices Act, M.G.L. c. 66A, § 2(I).

9.13: continued

3. The identity of a complainant shall not be disclosed by any provider involved, assuming it has knowledge of such identity, or by the Department, except to representatives of investigating state agencies (including the Department) or local police or the district attorney's office as necessary for investigation, review, and monitoring of the subject matter of the complaint.

(c) Custody. The senior investigator shall be the custodian of the case file, provided that:

1. where a matter is actively investigated, the investigator shall be given authority to access the case file; and

2. where the matter is appealed, the Commissioner shall hold the case file until the appeal is completed.

(2) Public Log. Each senior investigator shall, for his or her region, maintain a public log of medicolegal deaths and all complaints filed pursuant to 115 CMR 9.06, in such form as the Commissioner may from time to time prescribe.

(a) The log shall not include personal identities, and shall be a public record, available for inspection and copying by members of the public as provided in M.G.L. c. 66, § 10.

(b) The log will include a statement as to whether the complaint was substantiated, whether an appeal was filed, and the outcome of any appeal.

(c) The log shall note the manner of disposition of each complaint.

(d) The senior investigator shall forward all new information posted in his or her log each month to the office of the Director of Investigations, in which place the information shall be placed in parallel logs or databases and shall be similarly accessible to the public.

9.14: Miscellaneous Provisions

(1) Individual, Complainant and Witness Protection. The regional director or any official before whom a complaint or appeal is pending shall take immediate action pending investigation as he or she deems warranted to protect the health, and safety of any individual, complainant or witness. Any such action taken shall be documented and the documentation forwarded to the senior investigator for placement in the case file.

(2) Obstruction or Retaliation.

(a) Termination of Employment. Obstruction by any employee of an investigation properly conducted under 115 CMR 9.00, or retaliation by any employee against any person for making a complaint, complying with 115 CMR 9.00, or cooperating with an investigation, shall be grounds for discipline of such employee, up to and including dismissal.

9.14: continued

(b) Revocation of Contract, License, or Other Action. Obstruction by a provider of an investigation properly conducted under 115 CMR 9.00, or retaliation by any provider against any person for making a complaint, complying with 115 CMR 9.00, or cooperating with an investigation, shall be grounds for adverse action against the provider, including without limitation revocation of the Department's contract with such provider or revocation of the provider's license.

(3) Disqualification of Official.

(a) The regional director, the senior investigator, the investigator, or any other official with authority to act on a complaint shall disqualify himself or herself from so acting whenever the next higher official as set forth in 115 CMR 9.14(5) concludes, or he or she concludes that he or she cannot act on the matter impartially and objectively, in fact or in appearance.

(b) In the event of such a conclusion, the official shall prepare and forward within one day of receiving notice of the matter, a written, dated memorandum of his or her disqualification and the reasons therefor to the next higher official, as set forth in 115 CMR 9.14(5), who shall, within one day of receipt thereof, take such steps as are necessary to ensure the processing of the complaint in an impartial, objective manner.

(c) When a senior investigator has information leading him or her to believe that an investigator assigned to conduct an investigation cannot act impartially and objectively, in fact or in appearance, he or she shall disqualify the investigator and assign another. Such disqualification shall be documented in the case file.

(4) Request for Extension. The investigator, or any other official acting pursuant to 115 CMR 9.05 through 9.14 may request an extension of any time limit provided herein with the permission of the next higher official as set forth in 115 CMR 9.14(5), upon a showing of necessity and that the delay will not pose a threat to the safety or security of the individual involved. A request for such extension shall be in writing, with copies to the other parties and to the investigator, senior investigator and director (regardless of who is seeking the extension and who is the next higher official), and shall explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter. Such request shall be submitted to and acted upon by the next higher official prior to the expiration of the original time limit, who shall notify the parties.

(5) Next Higher Official. For purposes of forwarding a memorandum of disqualification, or requesting an extension of time for any official in Column 1, the memorandum or request shall be sent to the corresponding official in Column 2:

Column 1	Column 2
Investigator	Senior Investigator
Senior Investigator	Deputy Director of Investigations

9.14: continued

Case Management Director or Facility Director	Regional Director
Regional Director	Deputy Commissioner

(6) Other Investigations. The investigation by the Department provided for by 115 CMR 9.05 through 9.14 is independent of any investigation conducted by or on behalf of the police, the District Attorney, or other outside authorities, including the DPPC. 115 CMR 9.00 is not intended to lessen the independent authority given to those entities, including the inherent authority granted to the Department by M.G.L. c. 19B, as exercised by the Commissioner.

(a) The senior investigator may defer the Department investigation until other authorities have completed their investigation, in recognition that some investigations require the highly technical skills of law enforcement personnel, or in recognition of the need in some circumstances to avoid duplicative investigative effort. The senior investigator must determine

1. that a delay will likely not adversely affect the immediate health and safety of individuals served by the Department; and
2. that the results of the investigation by outside authorities is likely to affect the conclusion of the Department's investigation or that the investigation by outside authorities will likely address or resolve all relevant issues.

(b) The senior investigator is responsible for directing overseeing collaboration and communication with other investigating authorities, to both expedite the investigation process and to enhance the possibility of successful prosecution in cases of a substantiated felony.

(c) Where the senior investigator has deferred Department investigation, he or she may at any time change the disposition of the matter to active investigation, if he or she determines that investigation by the Department will not compromise or duplicate outside investigations, or will not likely be affected by the results of such outside investigations. Any change in disposition to active investigation requires a Change of Disposition Letter and must be noted in the log.

(7) Annual Audit. The Office of Quality Enhancement shall conduct an annual systems audit to determine the effectiveness of the investigations procedures contained in 115 CMR 9.00 and to monitor their implementation.

9.15: Reporting and Investigating Injury Resulting from Suspected Abuse by a Service Provider or Caretaker

(1) If a Department or provider employee has reasonable cause to believe that serious physical (including fatal) or emotional injury of a person with disabilities, including any individual served, resulted from an act or omission by a service provider or caretaker, whether by act or omission, he or she shall:

9.15: continued

(a) immediately call the DPPC and file a complaint under M.G.L. c. 19C, where the suspected victim of the abuse is 18 years or age or older, but under 60 years of age.
(b) immediately call the Department of Social Services and file a report under M.G.L. c.119, § 51A, where the suspected victim is under 18 years of age.
(c) immediately call the Department of Elder Affairs and file a report under M.G.L. c. 19A, § 15, where the suspected victim is 60 years of age or older.
(d) immediately call the Department of Public Health and file a report under M.G.L. c. 111, § 72G, where the suspected victim resides in a nursing home or similar establishment required to be licensed or certified by the Department of Public Health.

A "caretaker" is the person's parent, guardian, provider staff or other person or agency responsible for the person's health or welfare, whether in the same home as the person or any other day or residential setting.

(2) Reports filed with the DPPC shall be investigated in accordance with the regulations and procedures of that agency. The filing of a report with the DPPC does not negate or satisfy the duty to file complaints under 115 CMR 9.06.

9.16: Incident Reporting

(1) All incidents involving individuals served by the program which result in any of the following shall be reported by the program:
(a) physical injury which requires any medical treatment beyond routine first aid;
(b) emotional harm;
(c) significant property destruction;
(d) potential physical or emotional harm;
(e) police involvement;
(f) mistreatment.

(2) The staff person observing the incident must complete a written report of the incident within two hours of its occurrence, and file it with the service coordinator(s) assigned to the involved individual(s), the head of the provider, and the family or guardian, if any, within 24 hours.

(3) The incident report shall include:
(a) the person(s) involved;
(b) the date, time, and location of the incident;
(c) events preceding the incident;
(d) immediate action taken;
(e) any witnesses to the incident
(f) the extent of injury to the individual, if any, and any medical health care professional's comments on treatment, if medical treatment was necessary;

9.16: continued

(4) Where an individual served by the program has a physical injury of unknown origin requiring medical treatment beyond routine first aid, the staff person first observing the injury shall complete and file the incident report.

(a) The incident report in this instance shall indicate that the injury is of unknown origin.
(b) The incident report for an injury of unknown origin shall address the elements listed in 115 CMR 9.16(3), but shall address these elements in terms of the discovery of the injury rather than in terms of the occurrence of an incident.

(5) If the reporting staff person or head of the provider has reasonable cause to believe that serious physical or emotional injury of an individual served resulted from abuse or neglect, whether by act or omission, including non-consensual sexual activity, he or she shall *also*:
(a) immediately call the DPPC and file a complaint under M.G.L. c. 19C, where the suspected victim of the abuse is 18 years of age or older, but under 60 years of age.
(b) immediately call the Department of Social Services and file a report under M.G.L. c.119, § 51A, where the suspected victim is under 18 years of age.
(c) immediately call the Department of Elder Affairs and file a report under c.19A, § 15, where the suspected victim is 60 years of age or older.
(d) immediately call the Department of Public Health and file a report under M.G.L. c. 111, § 72G, where the suspected victim resides in a nursing home or similar establishment required to be licensed or certified by the Department of Public Health.

(6) Where the head of the provider has reasonable cause to believe that a felony has been committed in connection with an incident under 115 CMR 9.16(1), he or she shall file a report with the local police and district attorney.

(7) If an incident meets, or creates or results in a condition meeting, the requirements of 115 CMR 9.05, the head of the provider shall file a complaint with the Department under 115 CMR 9.06.

(8) Upon receipt of the incident report, the service coordinator shall prepare a written recommendation advising whether adjustments to the program or steps necessary to prevent similar incidents in the future are indicated, whether any component of the individual's ISP including behavior plans should be modified, and whether a complaint should be filed under 115 CMR 9.06, assuming one has not already been filed.
(a) The service coordinator shall send the recommendation to the facility director or designee, where the program is connected to one of the facilities, to the regional director where the program is a state operated community program, or to the case management team director with a copy to the head of the provider in all other cases. A copy of the recommendation shall become part of the individual's record.

9.16: continued

(b) Where the service coordinator has reason to believe that serious physical or emotional injury of an individual resulted from abuse or neglect, whether by act or omission, including non-consensual sexual activity, and where the incident has not been reported as required by 115 CMR 9.16(5), the service coordinator shall make the required report.

(9) In cases where the dignity or rights of the individual(s) involved are in question, the service coordinator shall refer the matter to the provider's human rights committee.

(10) The identity of persons making reports of mistreatment, or making reports pursuant to 115 CMR 9.16(5), shall not be disclosed by the provider or the Department, except to representatives of investigating state agencies (including the Department) or local police or the district attorney's office as necessary for investigation, review, and monitoring of the subject matter of the report.

9.17: Reporting Suspected Criminal Activity or Criminal Charges

(1) The investigator shall notify the police, the District Attorney and the General Counsel whenever he or she has reason to believe that a felony has been committed, provided that such notification shall not be made by the investigator unless approved by the senior investigator.

(a) In addition, the investigator shall notify the General Counsel and the Commissioner of Public Safety whenever there is:

1. injury by gunshot or bullet wound, powder burn or any other injury due to the discharge of a firearm; or
2. injury due to a knife or other sharp or pointed instrument if a criminal act may have been involved.

(2) The director shall immediately notify the General Counsel when:

(a) An individual served brings criminal charges against a Department or provider employee;

(b) Criminal charges are brought against an individual served;

(c) A Department or provider employee or individual served is indicted because of any action required to be investigated by 115 CMR 9.00;

(d) An employee or individual served is convicted on the charges or indictment described in 115 CMR 9.17(2)(a), (b), or (c).

(3) The reporting responsibilities set forth in 115 CMR 9.17, are in addition to all other reporting responsibilities set forth in 115 CMR 9.00.

9.18: Reporting Deaths

(1) All deaths of individuals, regardless of cause, and regardless where the individual resided immediately prior to death, shall be reported to the Office of the General Counsel in the manner directed by that office.

(2) Any Department or provider employee having reason to believe that an individual died a medicolegal death shall:

(a) file a complaint under 115 CMR 9.06 and 9.16; and

(b) notify the Medical Examiner, unless he or she has already taken jurisdiction of the case, who is required to inquire into the cause and circumstances of death and to take custody of the dead body if he or she is of the opinion that death may have resulted from violence or unnatural causes.

REGULATORY AUTHORITY

115 CMR 9.00: M.G.L. c. 19B, §§ 1, 10, and 14; c. 123B, §§ 2 and 14; c. 19C.

DMR Investigations Advisory Panel

Recommended Mandated Referrals to the District Attorney's Office at point of intake

(a) a person with a disability has died;

(b) a person with a disability has been sexually assaulted, as set forth in sections thirteen F (Indecent A&B on mentally retarded person), thirteen H (Indecent A&B person over 14), twenty-two (Rape), twenty four (Assault with intent to commit rape) of chapter two hundred and sixty-five or section thirty-five (Unnatural and lascivious acts) of chapter two hundred and seventy-two;

(c) a person with a disability has suffered bodily injury as set forth in section K of chapter two hundred sixty-five (A&B upon an elderly or disabled person-"Bodily injury"-substantial impairment of the physical condition, including, but not limited to, any burn, fracture of any bone, subdural hematoma, injury to any internal organ, or any injury which occurs as a result of repeated harm to any bodily function or organ, including human skin);

(d) a person with a disability has been sexually exploited as defined in sections three (Drugging persons for sexual intercourse) and seven (Support from, or sharing, earnings of prostitute) of chapter two hundred and seventy-two;

(e) a person with a disability has suffered serious bodily injury as the result of a pattern of repetitive actions by a caretaker;

(f) a person with a disability who has been financially exploited as defined in section thirty of chapter two hundred sixty-six (Larceny)

(g) discretionary referrals including but not limited to any felonies